



KIDS ADVENTURE PRESCHOOL

2021-2022 Registration Form

810 2nd Avenue Southwest, Perham, MN 56573
(218) 346-1618

LAST NAME: _____

Admin use only:

Date received: _____ by: _____

Reduced lunch form complete: _____
Qualify: F R

2-Day 4-Day
Funding Source: 01 02 04 05 11 12

Immunizations: UTD Exemption Need

Child's Full Legal Name: _____ Date of Birth: _____ Child's Sex: F M

Mother's Name: _____ Mother's Address: _____

Father's Name: _____ Father's Address (if different): _____

Mother's Employer: _____ Father's Employer: _____

Parent Contact Email Address: _____

Child Resides With: Mother ____ Father ____ Both ____ Other: _____
Address (if other): _____

Phone Number(s):

Mother's Home: _____ work: _____ cell: _____

Father's Home: _____ work: _____ cell: _____

Date of Preschool screening: _____ Child's age as of September 1: _____ Number in household _____

Child's resident school district: ____ Perham ISD 549 ____ Other (please indicate) _____

Please enroll your child by marking your first and second choices

3 year old program

- ___ 2 half day mornings
- ___ 2 half day afternoons
- ___ 4 half day mornings
- ___ 4 half day afternoons

4/5 year old program

- ___ 2 full days
- ___ 4 full days

(Days of the week TBD)

Photograph/Video Consent: I give permission to Kid's Adventure & ISD #549 Staff to record images of my child (please circle)

YES NO

Primary Language spoken in your home _____ The race/ethnicity of child _____

Request to send newsletters or progress reports to parent living outside of home:

Name: _____ Address: _____

Parent/Guardian Signature: _____ Date: _____

(I certify that all of the information provided is true and accurate. I understand this information is being given for the receipt of state funds, and school officials may verify the information on this application.)

(Please continue on reverse side)

Medical History (Please fill in every blank or write N/A where appropriate)

Allergies: Drug _____ Food _____

Special Medical/Mental Diagnosis _____

Heart Condition _____ Asthma _____ Seizures _____ Diabetes _____

Recent Illness or Surgery _____

Physical Disabilities _____

Childhood Diseases _____

Medications your child is taking _____

Name of Child's Medical Insurance Company _____

Child's MA # _____ MNCare # _____ Insurance # _____

Child's Family Physician _____ Phone # _____

Complete Address _____

Suggested Hospital _____ Phone # _____

Complete Address _____

Child's Family Dentist _____ Phone # _____

Complete Address _____

Is your child on an IEP (Individual Educational Plan)? _____

Census Information: Please list name and birth date of any other children living in your household

| Name | Date of Birth | Gender | Grade (if attending) | Relationship to Student |
|------|---------------|--------|----------------------|-------------------------|
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Parent/Guardian contact is critical in an emergency. We make every effort to contact you or one of the emergency contacts listed below. Your child will only be released to parents/guardian listed above or the persons listed below.

| | | | | |
|------|---------|-----------------|-------|--------------|
| NAME | ADDRESS | DAYTIME PHONE # | CELL# | RELATIONSHIP |
|------|---------|-----------------|-------|--------------|

1.) _____

2.) _____

3.) _____

If your child's daycare provider is not one of the contacts listed above, please provide the following information:

Child's Daycare Provider Contact Information _____ Phone # _____

I, THE UNDERSIGNED PARENT OR GUARDIAN, HEREBY GIVE MY CONSENT, IN THE EVENT OF AN EMERGENCY WHERE NEITHER MY FAMILY PHYSICIAN NOR I CAN BE CONTACTED, FOR THE ABOVE-NAMED CHILD TO BE TAKEN BY KIDS ADVENTURE STAFF TO THE NEAREST APPROPRIATE FACILITY FOR ALL NECESSARY MEDICAL CARE AS RECOMMENDED BY THE ATTENDING PHYSICIAN/DENTIST. I ACCEPT RESPONSIBILITY FOR ANY COSTS ARISING FROM SUCH TREATMENT THAT ARE NOT COVERED BY INSURANCE AND/OR MEDICAL ASSISTANCE. I HEREBY CONSENT TO HAVING A CONTACT CARD AVAILABLE IN THE CLASSROOM, ON THE CHILD'S BUS, AND IN THE KIDS ADVENTURE OFFICE.

SIGNATURE OF PARENT/GUARDIAN

DATE

SIGNATURE OF STAFF

DATE