

Office Use Only  
Date Enrolled:

**REGISTRATION FOR THE MILFORD PRESCHOOL, LLC**  
**35 MATHEW ST. MILFORD, CT 06460**  
**AT THE MARGARET EGAN COMMUNITY CENTER**  
**(203) 874-5666**

Name of child: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

D.O.B. Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_

Check session child will be attending: 4 yr. old morn: \_\_\_\_\_ 4yr. old afternoon \_\_\_\_\_ 3yr. old morn \_\_\_\_\_

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Parent(s)/Guardian(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

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Emergency Contact : \_\_\_\_\_ (Other than parent)

Emergency Phone # : \_\_\_\_\_ Relationship: \_\_\_\_\_

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Father's Occupation: \_\_\_\_\_ Work hrs: \_\_\_\_\_

Place of Employment:: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

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Mother's Occupation: \_\_\_\_\_ Work hrs: \_\_\_\_\_

Place of Employment:: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

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Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does the child have any siblings? If so, please list names and ages: \_\_\_\_\_

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Favorite Toy: \_\_\_\_\_ Book: \_\_\_\_\_ Pet: \_\_\_\_\_  
Does the child have any particular mannerisms, habits, such as nail biting or thumb sucking?

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Has your child had any previous play group experience? Please describe: \_\_\_\_\_

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As far as you know, does child have any language problems or learning disabilities?  
Eyesight?Hearing?: \_\_\_\_\_

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Have there been any recent changes within the family such as birth of a sibling, death of a close relative, a divorce or major illness? Please explain: \_\_\_\_\_

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Who is the primary caregiver for your child?: \_\_\_\_\_

Is there an extended family/relative closely involved with the child?: \_\_\_\_\_

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Does your child require the administration of automatic injectable equipment(i.e. EpiPen EpiPen Jr) to treat severe allergic reactions? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, you will need to fill out additional medical and authorization forms that are required by law to be attached to your child's file before the staff are allowed to administer the automatic injectable equipment. In addition it is also mandated by law that you (parent/guardian) must provide the injector and a copy of the prescription for such medication. You (parent/guardian) are also responsible for the replacement of such medication and equipment prior to its expiration date.

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Is there anything regarding your child's physical/emotional status that we should be aware of i.e.: common allergies, activity level? Explain \_\_\_\_\_

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**THE MILFORD PRESCHOOL, LLC**  
**RELEASE PERMISSION**

I hereby give permission for the following people to take my child (child's name) \_\_\_\_\_ off the premises of the Milford Preschool other than the preschool staff.

<b><u>Name</u></b>	<b><u>Relationship to Child</u></b>	<b><u>Phone #</u></b>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Parent or Legal Guardian)

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**THE MILFORD PRESCHOOL, LLC**  
**PERMISSION AGREEMENT**

A. I/we grant permission for my child (name) \_\_\_\_\_  
to use all of the play equipment and participate in all of the activities of the school, unless  
exceptions are noted here: \_\_\_\_\_  
\_\_\_\_\_

B. I/we grant permission for my child to leave the school premises under the supervision  
of a staff member for neighborhood walks.

C. I/we grant permission for my child to be included in evaluations and pictures  
connected with the Preschool's program.

D. I hereby grant permission for the director or acting director to take whatever steps may  
be necessary to obtain emergency medical care if warranted. These steps may include,  
but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact a child's physician.
3. Attempt to contact the parent through any of the persons listed on the emergency  
information card completed for the center. (Note: It is the parent's responsibility to keep  
this card up to date.)
4. If we cannot contact the parent or the child's physician, we will do any or all of the  
following:
  - a. Call another physician
  - b. Call an ambulance
  - c. Have the child taken to any emergency hospital in the company of a staff  
member.

5. Any expenses incurred under 4 above will be borne by the child's family.

E. The school will not be responsible for anything that may happen as a result of false  
information given at the time of enrollment.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Parent or Legal Guardian)

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## **EMERGENCY INFORMATION**

*Please print clearly*

### **STUDENT INFORMATION:**

Name: \_\_\_\_\_ Class Year: \_\_\_\_\_  
*Last First Middle*

Address: \_\_\_\_\_  
*# Street City St Zip*

Parent/Guardian: \_\_\_\_\_  
*Relationship if other than parent*

Home Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_ Birth date: \_\_\_\_\_

Primary language spoken at home \_\_\_\_\_

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### **FATHER INFORMATION**

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City, ST, Zip \_\_\_\_\_ Home Phone : \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

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### **MOTHER INFORMATION**

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City, ST, Zip \_\_\_\_\_ Home Phone : \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

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### **FAMILY INFORMATION**

Parents are: living together: \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ Legal contact allowed: \_\_\_yes \_\_\_no

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### **IMMEDIATE MEDICAL ATTENTIONN INFORMATION:**

*Signature Required*

If an injury occurs which is judged to require immediate medical attention and the contact person listed on the reverse side cannot be reached, Milford Preschool, LLC has my permission to have my child transported to a medical facility for treatment.

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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