



208 Columbus Avenue
New Haven, CT 06519
203-772-2424

PRE-KINDERGARTEN APPLICATION FORM

Student Information:

Date: _____

Child's Name: _____ Male _____ Female _____
First Middle Last

Address: _____
Street Name City State Zip Code

Date of Birth: ____/____/____ Birthplace: _____ Race: _____ Religion: _____

Does your child have health insurance: Yes ___ No ___

Health Provider: Husky: _____ Private: _____ Insurance # _____
Plan A or Plan B Name of Provider

Guardian Information:

First Parent or Guardian's Name: _____

Relation to child: Mother _____ Father _____ Other _____ Marital Status: _____

Address: _____
Street Name City State Zip Code

Telephone #s: Home () _____ Cell () _____ Work: () _____

Occupation: _____ Place of Employment: _____

Work Address: _____

Gross Weekly Pay _____ Other Forms of Income: _____ Amount _____

Second Parent or Guardian's Name: _____

Relation to child: Mother _____ Father _____ Other _____ Marital Status: _____

Address: _____
Street Name City State Zip Code

Telephone #s: Home () _____ Cell () _____ Work: () _____

Occupation: _____ Place of Employment: _____

Work Address: _____

Gross Weekly Pay _____ Other Forms of Income: _____ Amount _____ →

Total number of people in your household, (include yourself): _____

List all dependent children in your household, including the child listed on the front of the form:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

List any additional adults living in the household, other than the ones listed on the front:

Name: _____ Relation to child: _____

Name: _____ Relation to child: _____

Name: _____ Relation to child: _____

My signature below indicates that I understand and agree to adhere to all of the stated policies and procedures of Saint Martin de Porres Academy Pre-K program.

Name of person who completed the application:

Signature: _____ Date: _____

Printed Name: _____ Relation to Child: _____



St. Martin de Porres Academy- Pre-K
Emergency Information Sheet

Student's Name: First Middle Last M F Date of Birth: / /

Address: # Street Name City State Zip Code

Child Lives with: Both parents: Mother Father Other: (relationship)

Physician Name / Health Facility: Phone # ()

Dentist Name / Dental Facility: Phone # ()

Hospital preferred in case of emergency: Yale New Haven Hospital: Hospital of St. Raphael:

Allergies / Medications:

Health Provider: Husky Private: Ins. # Plan A or Plan B Name of Provider

No Insurance:

First Parent/Guardian Information:

Mother: Father: Other: (relationship to child) Marital Status:

Name: First Last Home Phone # () Cell # ()

Address: # Street Name City State Zip Code

Place of Employment: Work Phone # ()

Work Address: # Street Name City State Zip Code

Second Parent/Guardian Information:

Mother: Father: Other: (relationship to child): Marital Status:

Name: First Last Home Phone # () Cell # ()

Address: # Street Name City State Zip Code

Place of Employment: Work Phone # ()

Work Address: # Street Name City State Zip Code

The following people are authorized to transport, drop off and pick up my child. These people are at least 18 years of age and understand that they may be required to show identification.

1. Name: _____ Relationship to child: _____

Phone # () _____ Alternate Phone # () _____

2. Name: _____ Relationship to child: _____

Phone # () _____ Alternate Phone # () _____

3. Name: _____ Relationship to child: _____

Phone # () _____ Alternate Phone # () _____

4. Name: _____ Relationship to child: _____

Phone # () _____ Alternate Phone # () _____

5. Name: _____ Relationship to child: _____

Phone # () _____ Alternate Phone # () _____

I understand that the people listed may be called for the following circumstances, but not limited to picking up my child in the event of late pickup, in emergency situations, illness of my child, school closings and for other necessary occurrences.

I give permission to the program and school staff to administer first aid treatment and / or seek emergency medical care for my child, if deemed necessary.

Signature of parent or guardian Date

Printed name of parent or guardian

Changes made: _____
Signature of parent or guardian Date

Child/Family Personal History

The purpose in securing this information about your child is to help the child care provider better understand your child and to help you know what to expect from the child care program. Your child's care during the day is a responsibility we share. All information is kept confidential and requires your written permission if it is to be shared. Please use the back side of the form if you wish to elaborate more on a question. Some questions may not be applicable to your child at this time—please leave such questions blank.

Family and Social History

Date: _____

Child's Full Name: _____	
Address: _____	
Date of Birth: _____	Place of Birth: _____ Home Phone () _____
Race: _____	Religion of child: _____
Your Name: _____	Relation to Child: _____
Present dwelling: <input type="checkbox"/> house <input type="checkbox"/> duplex <input type="checkbox"/> apartment <input type="checkbox"/> mobile home <input type="checkbox"/> other type (list): _____	
Mother/Guardian Work Phone _____	Father/Guardian Work Phone _____
Has the child moved frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian	
Is the child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, at what age? _____ Does the child know? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status of Parent(s)/Guardian(s): <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single Parent <input type="checkbox"/> Widowed If divorced, separated, or widowed, for how long? _____	
Mother's Name _____	Education _____
Father's Name _____	Education _____
Guardian's Name _____	Education _____
Please provide details of any custody or visitation agreements. Please provide a copy of any court order dealing with custody and/or a copy of any restraining orders. _____ _____	

Please list names and ages of your child's siblings or other children living in the household:

Name:

Age:

_____	_____
_____	_____
_____	_____
_____	_____

Adults (other than you) living in your household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

How long have you lived in this city?

What language(s) is/are spoken in your home?

English Spanish Other: _____

Language(s) my child speaks: _____

Language(s) my child understands: _____

Are there any special words that would help us communicate with your child?

Are there any cultural practices or holidays you would like us to know about?

Personal History

Age the child began: Sitting _____ Crawling _____ Walking _____

Is the child a good climber? Yes No

Does the child fall easily? Yes No

Age the child began talking: _____

Does the child speak in words or sentences?

Does the child use any special words to describe his/her needs? Yes No

If yes, please describe:

Sleeping

How many hours of sleep does your child get each night? _____ What time does your child go to bed? _____

Is the child able to get to sleep by him/herself? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the child have a room to him/herself at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the child sleep in his/her own bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the child walk, talk, or cry out at night? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle those that apply.	
Does the child take anything special to bed with him/her? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what item(s)?
What is the child's mood on awakening?	
Does the child take naps?	If so, at what time and for how long?

Social Relationships

Has the child had experiences playing with other children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Approximately how much time does your child spend watching TV or using the computer each day?	
Please check the words that best describe your child:	
<input type="checkbox"/> <input type="checkbox"/> confident	<input type="checkbox"/> <input type="checkbox"/> loving
<input type="checkbox"/> <input type="checkbox"/> secure	<input type="checkbox"/> <input type="checkbox"/> shy
<input type="checkbox"/> <input type="checkbox"/> responsible	<input type="checkbox"/> <input type="checkbox"/> anxious
<input type="checkbox"/> <input type="checkbox"/> self-reliant	<input type="checkbox"/> <input type="checkbox"/> follower
<input type="checkbox"/> <input type="checkbox"/> quiet	<input type="checkbox"/> <input type="checkbox"/> cooperative
<input type="checkbox"/> <input type="checkbox"/> excitable	<input type="checkbox"/> <input type="checkbox"/> loud
<input type="checkbox"/> <input type="checkbox"/> energetic	<input type="checkbox"/> <input type="checkbox"/> other (please list):
How does the child get along with siblings?	
How does the child get along with adults?	
With what age child does the child prefer to play? <input type="checkbox"/> Younger <input type="checkbox"/> Older <input type="checkbox"/> Same Age	
Will the child know any other children at this Pre-K facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child attended another care center? _____ If yes, where: _____	
Do you feel the child will adjust easily to the child care situation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please explain:	

What makes the child angry or upset?

How does the child show his/her feelings?

Does your child have any behavior issues you are concerned about?

What method of behavior guidance is used in your home?

What is the child's usual reaction to this method?

Who does most of the disciplining in your household?

Is the child frightened by any of the following: animals tall people rough children
 loud noises dark storms other:

What materials or activities hold your child's interest? (Check all that apply).

books blocks drawing
 painting dramatic play music
 puzzles science material sand or water play

Does the child like to be read to? Yes No Does the child like to listen to music? Yes No

Does the child prefer to play indoors or outdoors? Indoors Outdoors No preference

Has the child had experience with: clay scissors easel painting finger-painting blocks
 water play books

Does your child have any habits (nail biting, thumb sucking, etc.) or other issues that we should be aware of? Yes No

If yes, please explain:

Health History of Child

What past illnesses has the child had?

- Chicken Pox
- Scarlet Fever
- Diabetes
- Malaria
- Measles

- Hepatitis A
- Hepatitis B
- Mumps
- Other:

Does the child have frequent

- colds tonsillitis earaches/ear infections stomachaches other:

Does the child vomit easily? Yes No

Does the child often run high fevers? Yes No

Has your child had any serious accidents or poisonings? Yes No

If yes, please describe:

Is the child allergic to anything? Yes No

If yes, please describe:

How does the allergy usually manifest itself?

- Asthma Hay Fever Hives Other:

Has the child ever been hospitalized? Yes No

If yes, please describe:

Is your child currently being seen by a medical specialist? Yes No

If yes, for what reason?

Has your child been evaluated for or receive special services?: (such as Birth to Three, Child First, Family Therapy, etc.): Yes No

If yes, please give details:

Has the child ever been to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child use a bottle or pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the child had his/her vision tested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any health-related needs you would like us to be aware of? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
Please give a statement of your evaluation of your child's overall health.	
What kind of things can your child do by him/herself?	
Eats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dresses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Washes hands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ties shoes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eating

Is the child usually hungry at mealtime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Between meals? <input type="checkbox"/> Yes <input type="checkbox"/> No
What are the child's favorite foods?	
What foods does the child dislike?	
Does the child have any eating issues that you feel we should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
Does child eat with a: <input type="checkbox"/> spoon <input type="checkbox"/> fork <input type="checkbox"/> hands	
Is child left- or right-handed? <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> don't know yet	

What time does your child usually eat breakfast?	lunch?	dinner?
Is your family vegetarian or vegan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain any dietary restrictions for the child:		
Please note any other dietary restrictions: (physical, religious, cultural, etc.)		

Toilet Habits

Is your child toilet trained? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can the child be relied on to indicate his/her toileting needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child need to use the toilet more frequently than usual for his/her age? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:
Is the child frightened of the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child have toileting accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No
How does the child react to toileting accidents?
Does child need help with toileting? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:
Was the child easy or difficult to toilet train? <input type="checkbox"/> Easy <input type="checkbox"/> Difficult
Does the child wet his/her bed at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how often?
Additional Information:

Is there any additional information that you would like to share about your child? (such as family and cultural celebrations, religious affiliations, cultural restrictions or other requirements, recent changes or circumstances in your family or household, etc.):

What are your expectations and goals for your child at pre-kindergarten? In what particular ways can we help your child?

parent signature

date