St. Gabriel of the Sorrowful Virgin
5200 Greenridge Drive
Pittsburgh, PA 15236

2019-2020 Preschool Program Registration

Childs name: ____
(First) (Middle) (Last)

Nickname: ______________Birth Date: ____________ Gender: M____ F____

Address: ____

____

Parish Membership: St. Gabriel__________ Other(list)__________________

Parent/Guardian Name: ____

Cell Phone: ______________________ Occupation:______________________

Email address: ____

Parent/Guardian Name: ____

Cell Phone: ____________________ Occupation: ______________________

Email:____

****Email will be used for preschool communication and the school One Call Information system for inclement weather notification****

Please mark 1st and 2nd choice for which session you would like to register your child:

3/4 yr T/TH
________________(**8:45-11:00**)
________________ (**12:45-3:00**)

4/5 yr M/W/F
_________________(**8:30-11:00**)
_________________(**12:30-3:00**)

4/5 yr M/T/W/Th/F
__________________(**12:30-3:00**)

In case of Emergency please designate, in order, who should be contacted. Please list at least 3.
(If there are specific custody arrangements, please inform staff and submit copies of relevant court documents)

Name Phone Number Relationship to child

1. ____

2. ____

3. ____

For your child's protection he/she will not be released to any unauthorized person. Please list the people you permit your child to meet at dismissal time.

Name Phone Number Relationship to child

1. ____

2. ____

3. ____

4. ____

STAFF USE ONLY:

Registration fee enclosed: yes______ no _______ ck # ________cash__________

Copy of immunization record attached: yes _______ no ________

RELEASES

Throughout the school year, pictures are taken of the children as they engage in normal daily activities. The pictures are used at meetings, in conjunction with projects, for bulletin boards and for portfolios. Occasionally photographs of the children in our program are requested for parish and/or Diocesan communications. If we do not have your signature please understand that we will not be able to include your child's picture in our projects.

I permit ______________________________to **be included when pictures are taken**
(print child's name)
during preschool sessions and activities.

Please check here to decline__________

Parent/guardian signature: _____________________________ Date: ___________

I permit ____________________________ **to be included in the class roster** for his/her
(print child's name)
preschool class to be distributed to that group.

Please check here to decline_________

Parent/guardian signature: ____________________________ Date: ____________

We are proud that family involvement is an integral component to our program and has proven to be a very successful and dynamic one. Through generous and enriching parent/family participation, our young children, their families, and our staff have benefited greatly.

If you would consider assisting us in this special enhancement of our program, through an interest, hobby, collection, career, or other, please complete the information below. (Ex. Police officer, dentist etc)

Family member's name: ____

Would like to share:

Hobby/skill: ____

Collection: ____

Pet: ____

Thank you in advance for your contribution!

Information about your child

Any known allergies: yes__________ no _________
If yes, please describe:

____

Has your child attended library story time, play group or other child's activity group?

____

Does your child have playmates his/her own age? _______________________

Does your child take medication on a regular basis? If so please describe:

____

Does your child have any physical characteristics of which we should be familiar?

____

Does your child have any fears which may affect participation in the group?

____

Does your child currently receive any services outside of school?(DART, TSS, Speech)

____

Please list all family members and any pets in household. We refer to this during discussions for prompting ideas and language development, as well as spelling for projects.

____

____

____

Please list any additional comments or concerns:

____

____

____

____

ST. GABRIEL PRESCHOOL PROGRAM

PLEASE COMPLETE MEDICAL INFORMATION AND SIGN BELOW

Student's Name Last:_____________________________First:____________Middle:________

Student's Physician __________________________________Phone #_____________________

In case of emergency, should student's physician be contacted if parent is unavailable? Yes No

Current Medications and dosages ___________________________________

Any special dietary restrictions?
____

Please describe the reaction and treatment if your child has a severe allergic reaction to the following:

Bee Sting or other stinging insect: _______________________________________

Reaction______________________________Treatment________________________________

Food allergies: Type of food: (ex. Nuts)____

Reaction_______________________Treatment_____________________

Other severe Reaction_________________________Treatment_____________________

I give consent for my child to receive minor first aid (bandaid, ice,etc.) Yes____ No____

If your child has a severe allergy requiring the use of an Epipen or Benadryl, you must submit a written physician's order, parental or guardian's written consent and the medication for treatment following a severe allergic reaction.

In an emergency, the E.M.S. will take the student to the nearest hospital. Every effort will be made to contact the parent/guardian prior to transport. If you prefer other arrangements, please state:____.

No treatment except life saving procedures will be given at the hospital without consent of parent, authorized relative or guardian. The staff must also be made aware of any changes in health conditions, or newly diagnosed conditions listed above, as well as any changes in addresses, phone numbers or emergency contacts.

Student medical records, are considered educational records and will be shared with staff who have a legitimate educational interest in the information and a need to know medical information to protect the safety and health of the student. Once provided, specific parental consent will not be sought to share information on a need to know basis. Parental requests to maintain the confidentiality of specific medical information must be made in writing.

Parent/Guardian Signature ________________________________ Date:______________