

ST. JOHN THE BAPTIST CATHOLIC SCHOOL  
315 N. CONSTITUTION AVE.  
NEW FREEDOM, PA 17349  
717-235-3525

2019-2020 REGISTRATION AND EMERGENCY FORM

**TIME FOR TWO'S CLASS  
TUESDAY – 9:00-11:00**

CHILD'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ARE YOU PRESENTLY A REGISTERED MEMBER  
OF ST. JOHN'S PARISH? YES \_\_\_\_\_ NO \_\_\_\_\_

PARENTS OR GUARDIAN WITH WHOM THE CHILD LIVES: \_\_\_\_\_

ETHNICITY \_\_\_\_\_

FATHER'S FULL NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
FATHER'S RELIGION \_\_\_\_\_ WORK # \_\_\_\_\_  
EMAIL \_\_\_\_\_ CELL # \_\_\_\_\_

MOTHER'S FULL NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
MOTHER'S RELIGION \_\_\_\_\_ WORK # \_\_\_\_\_  
EMAIL \_\_\_\_\_ CELL # \_\_\_\_\_

**PERSONAL HISTORY**

PREVIOUS SCHOOL EXPERIENCE, IF ANY (*CHECK ALL THAT APPLY*)

\_\_\_\_\_ 5 Day ½ Sessions \_\_\_\_\_ Play Group  
\_\_\_\_\_ Nursery School \_\_\_\_\_ Day Care  
\_\_\_\_\_ Babysitter with other children \_\_\_\_\_ St. John's

PLEASE LIST ANY MEDICAL CONDITIONS: (Allergies, Asthma, Speech Therapy, Glasses, etc.) \_\_\_\_\_

**If there is a need for teachers and/or aides to administer medication of any type to your child while in preschool, we must have a signed note from the parent and child's physician.**

WHAT WORDS DOES YOUR CHILD USE FOR TOILETING: \_\_\_\_\_

DOES YOUR CHILD HAVE ANY BOWEL OR BLADDER IRREGULARITIES? \_\_\_\_\_

ANY SPECIAL FOOD OR EATING INSTRUCTIONS? \_\_\_\_\_

ANY ADDITIONAL INFORMATION SUCH AS DISCIPLINE, CHILD'S COMMUNICATION, COMFORTING, ETC? \_\_\_\_\_

**(OVER)**

**FAMILY INFORMATION**

NUMBER OF PEOPLE AT HOME \_\_\_\_\_ AGES OF THE CHILDREN \_\_\_\_\_

PLEASE LIST ANY OTHER PERSONS LIVING WITH THE CHILD & THEIR RELATIONSHIP (IF ANY) TO THE CHILD

\_\_\_\_\_

**EMERGENCY CONTACTS**

**NAME/RELATIONSHIP TO CHILD**

**PHONE #**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DAYCARE PROVIDER ON CLASS DAYS**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PERSONS WHO **ARE NOT AUTHORIZED** TO PICK-UP MY CHILD/CHILDREN

\_\_\_\_\_  
\_\_\_\_\_

SCHOOL DISTRICT MY CHILD WILL ATTEND UPON LEAVING PRESCHOOL \_\_\_\_\_

**REGISTRATION FEE: \$20.00 - NON-REFUNDABLE (Due at time of registration)**  
**WE MUST HAVE PHOTOCOPY OF IMMUNIZATION RECORD ON OR BEFORE FIRST DAY OF SCHOOL**

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**FOR OFFICE USE ONLY:**

Registration Date \_\_\_\_\_

Registration Fee: \_\_\_\_\_ Check # \_\_\_\_\_  
(receipt \_\_\_) Cash \_\_\_\_\_

**PHOTOCOPY OF IMMUNIZATION RECORD**

\_\_\_\_\_ ON FILE \_\_\_\_\_ WITH REGISTRATION