



## Green Valley Methodist Preschool & Kindergarten

**2200 Robindale Road**

**Henderson, NV 89074**

School Year: \_\_\_\_\_

### Student Information Form

Student's Name \_\_\_\_\_ Date of Enrollment \_\_\_\_\_

Student's Nickname \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

If the child is not living with his or her birth mother and father, please complete the following:

Father \_\_\_\_\_ Mother \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

I give permission for the non-custodial parent, \_\_\_\_\_, to pick up the child during or after school. \_\_\_\_\_.

(Signature of Custodial Parent)

Others in household: (please list all who live in house plus ages) \_\_\_\_\_

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If there should be an emergency between the hours of 9:30 a.m. and 12:30 p.m., please list the person and phone number in the order of preference to call.

1. Name \_\_\_\_\_ Phone/Cell \_\_\_\_\_

2. Name \_\_\_\_\_ Phone/Cell \_\_\_\_\_

3. Name \_\_\_\_\_ Phone/Cell \_\_\_\_\_

Additional persons who are authorized to pick up your child from GVM Preschool & Kindergarten:

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have any special needs or fears? Explain: \_\_\_\_\_

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Are the needs serious enough to restrict the child's activities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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**Is the child allergic to any foods or other substances? If so, name food(s) or substances to be avoided and procedure to follow if reaction occurs. If the allergy is severe, we may ask you to bring snacks for your child to keep on hand at school.**

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Is there any physical condition that the staff should be aware of and what precautions should be taken?

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In your opinion, what is your child's greatest quality? \_\_\_\_\_

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Please check the item(s) below that pertain to your child:

_____ A listener/not talker	_____ Quiet & Reserved	_____ Socially Outgoing
_____ Separation Anxiety	_____ A leader	_____ Good verbal expression
_____ Imitates others	_____ Shy/Bashful	_____ Inquisitive

Please indicate if your child has or has had any of the following conditions:

_____ Allergy to bee stings	_____ Chicken Pox	_____ Headaches
_____ Allergies	_____ Diabetes	_____ Heart Murmur
_____ Asthma	_____ Epilepsy	_____ Hepatitis

List fractures and operations:

Type \_\_\_\_\_

Date \_\_\_\_\_

Type \_\_\_\_\_

Date \_\_\_\_\_

Is your child allergic to any drug? \_\_\_\_\_ Yes \_\_\_\_\_ No    If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Is your child currently being prescribed medication? \_\_\_\_\_ Yes \_\_\_\_\_ No    If yes, for what reason? \_\_\_\_\_

\_\_\_\_\_

Is this a chronic illness?

\_\_\_\_\_

Physician and Dentist to be called in an emergency:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If physician cannot be reached, what action should be taken?

\_\_\_\_\_ Call nearest hospital    \_\_\_\_\_ Other    Explain: \_\_\_\_\_

\_\_\_\_\_

If emergency service involving medical action or treatment is required and neither parents nor guardian can be contacted, I hereby consent for my child to be given medical care by the doctor selected by the school. This might include ambulance service. I understand this treatment will be at my/our own expense.

Mother \_\_\_\_\_ Date \_\_\_\_\_

(Print and Sign Name)

Father \_\_\_\_\_ Date \_\_\_\_\_

(Print and Sign Name)