Mt. Olivet Preschool
315 High Street
Seaford, Delaware 19973
302.629.4458

Application for: (check one)
Current Student: ____ Date: _____
Sibling of current student: ____
New Student: ____

Program Requested: (check one)
Two-year-old ____ (Must be 2 by 8-31-18)
Three-year-old ____ (Must be 3 by 8-31-18)
Four-year-old ____ (Must by 4 by 8-31-18)

Child's Name_____Sex_____

Address_____

Date of Birth_____Nickname_____Phone_____

Who has primary custody of this child? _____

Would you like the Preschool newsletter e-mailed to you? ___yes ___no e-mail_____

* * * * * * * * * *

Mother's Name_____

Address_____ Home Phone _____
Cell Phone _____
Employer_____Work Phone _____

* * * * * * * * * *

Father's Name_____

Address_____ Home Phone _____
Cell Phone _____
Employer_____Work Phone _____

* * * * * * * * * *

Names and Ages of Siblings_____

_____

What is your child's primary language?_____ Second language?_____

Does your child need any special considerations? Yes___ No ___ If yes, please explain the need._____

_____

* * * * * * * * * *

List two people who could be contacted in an emergency, if a parent could not be reached.

_____
Name Relationship Phone

_____
Name Relationship Phone

The immunizations required for this program are: **DPT 1, 2, 3; the Polio Vaccine 1, 2, 3; HIB 1, 2, 3; HEP B 1, 2, 3; MMR and Varicella(chickenpox).**

Recommended**: Pneumococcal and Rotavirus**

The State of Delaware requires each child have a Health Appraisal by a licensed physician or nurse practitioner, conducted within 6 months of when they start school. We will need a copy of this Health Appraisal on or before the first day of school.

Child's physician or source of health care_____

Address_____Phone_____

Please describe any allergies or special medical needs. _____

_____

_____

* * * * * * * * * *

For **EMERGENCIES** requiring immediate medical attention, your child _____
(child's name)
will be taken to the nearest hospital emergency room. Your signature below authorizes the responsible person at the school to have your child transported to the hospital.

Please sign to indicate your understanding of the school's policy concerning medical emergency situations.

Parent Signature_____Date_____

* * * * * * * * * *

Field Trip Permission: I give my child, _____,
(child's name)
permission to go on all field trips during school hours for the 2018-2019 school year. I understand that the school does not arrange transportation. Prior notice of all trips will be given.

Please sign to indicate your understanding of the school's policy concerning field trips.

Parent Signature_____Date_____

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Non-Parent Caregiver Information

Caregiver's Name_____ Relationship_____

Address_____

Home Phone_____ Cell Phone_____

Note: A non-refundable registration fee **must** be submitted with this application.
Checks should be made payable to Mt. Olivet Preschool.