Little *Griffins*

Preschool 2018-2019 Application

Preschool program for Diller-Odell Public Schools (Children ages 4 and 5)

CHILD INFORMATION:

Child's Legal Name: **Last**_____ **First**_____

Race Black White Native American Asian Pacific Islander

*Child's SS #*_____-_____-_____ *Gender*: **F** **M** *Age*: (Years-Months) _____-_____ *Birthday*_____/_____/_____

Primary Language:_____ *Secondary Language*:_____ *English Prof* _____ (O-None, 1-Poor, 2-Moderate, 3-Proficient)

Nationality _____ *(El-El Salvador, GU-Guatemala, MX-Mexico, PH-Philippines, PR-Puerto Rico, US-United Sates, VI-Vietnam, Other_____) Ethnicity* _____ (FI-Filipino, GU-Guamanian, HI-Hispanic, MC-Mexican/Chicano, PR-Puerto Rican, VT-Vietnamese, WH-White (Non-Hispanic) Other_____)

FAMILY INFORMATION:

*Primary Adult/Guardians*_____

*Living Address*_____ *City*_____ *State*_____ *Zip*_____

Mailing Address (if different)_____**Email:**_____

Phone: *First Contact #* **C**ell **H**ome (_____) _____ - _____

Second Contact # **Cell** **Home** **(**_____**)** _____ - _____

Place of Work:_____ *Contact#*_____

Foster Parent: **Y**es **N**o *Parental Status*: **O**ne-Parent **T**wo-Parent

No. Persons: **In Family**_____ *No. Children*: **In Family**_____

Diller-Odell Little Griffins preschool is a state grant-funded program. The following information is needed to continue use of grant funding. Please select the best choice for the following based on primary adult(s) in the home.

First & Last Names _____ **Birthday** ___/___/___ **Social Security #** _____-_____-_____ **Gender** F M

Education Level _____ (G9=9th grade or less, G10=10th Grade, G11=11th grade, G12=12th Grade, HSG=High School Grade, GED=General Education Diploma, COL=Some College, GTG=College Degree/Training Cert., A=Associates Degree, B=Bachelor's Degree, M=Master's Degree)

Employment Status _____ (F=Full time, P=Part Time, S=Seasonal, B-Full Time Work/Training, L=Part Time Work/Training, U=unemployment, R=Retired/Disabled, T=Training School

Race Black White Native American Asian Pacific Islander *Primary Language*:_____ *Secondary Language*:_____

English Prof _____ (O-None, 1-Poor, 2-Moderate, 3-Proficient)

Nationality _____ *(El-El Salvador, GU-Guatemala, MX-Mexico, PH-Philippines, PR-Puerto Rico, US-United Sates, VI-Vietnam, Other_____) Ethnicity* _____ (FI-Filipino, GU-Guamanian, HI-Hispanic, MC-Mexican/Chicano, PR-Puerto Rican, VT-Vietnamese, WH-White (Non-Hispanic) Other_____)

First & Last Names _____ **Birthday** ___/___/___ **Soc Sec #** _____-_____-_____ **Sex** F M

Education Level _____ ***(G9=9th grade or less, G10=10th Grade, G11=11th grade, G12=12th Grade, HSG=High School Grade, GED=General Education Diploma, COL=Some College, GTG=College Degree/Training Cert., A=Associates Degree, B=Bachelor's Degree, M=Master's Degree)***

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HEALTH CARE/INSURANCE INFORMATION:

Private Health Insurance Company:

_____

Does Child have an Educational Disability (IEP)? **Y**es **N**o **S**uspected

*Describe*_____

Diagnosed By: _____ *Date of Diagnosis*: _____

Is the child r*eceiving services*? **Y**es **N**o Who is the p*rovider*:_____

Does child have special needs or health problems? **Ye**s **N**o

Describe:_____

Referred to program by other agency/professional? **Y**es **N**o *By Whom & Why*_____

_____

Any specific family need or crisis? **Y**es **N**o *Describe*:

_____

_____

Does the family receive Public Assistance Benefits: **Yes No** *List the Benefits Received:*_____

_____

ALLERGIES and MEDICAL ISSUES:

Note: Medication must be supplied by parent(s)/guardian(s) and sent in the original container that details doctor's orders. Parent must also fill out the authorization for self-administration of medications at school and turn return to office (the doctor must sign this form) before any medication can be given. If your child has Asthma, a separate form will need to be filled out after the start of school.

(Please circle Yes or No to the following questions:)

Chicken Pox yes no Date_____

Bee/wasp Sting Allergy yes no Medication_____

Asthma yes no Medication_____

Medicine/Drugs yes no Medication_____

Food Allergies _____
Other Allergies_____

Is student currently taking medication/drug? If yes, what kind?_____

Does student have epilepsy or other seizure disorder? Yes ___ No ____

Other: Corrective glasses/contact lens, hearing impairment, or health (physical or emotional) or behavioral problems_____

Family Doctor _____ Phone _____

Do you carry Health Accident Insurance? Yes ___ No ____ Carrier's Name _____

Do you have other children in your household? Please include pre-school children.

Last name	First name	Middle Name	Date of Birth	Grade & School (if attending)

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this school district's programs may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the school district and is accessible to me during normal business hours.

Signature_____ **Date**_____

Please Note: A copy of the child's birth certificate and immunizations record will be needed prior to the start of preschool.