## Little Griffins



## Preschool program for Diller-Odell Children ages 4-5.

Preschool 2020-2021 Application

CHILD INFORM Child's Legal Name			First			
Race Black White	e Native Amer	ican Asian				
Child's SS #	S	Sex: F M	Age: (Years-Months)	Birthday	/	
				(O-None, 1-Poor,		
Nationality	(El-El Salvado	r, GU-Guatema	ıla, MX-Mexico, PH-Philip	ppines, PR-Puerto Rico, US- -Mexican, Chicano, PR-Puerto	-United Sate	s, VI-Vietnam,
FAMILY INFOR			City	Sta		7:-
Mailing Address (if d	ifferent)			Email:		
Phone: First Conto Second Con Place of Work:	tact # Cell	Home Home		 Contact#		
Foster Parent: Yes						
	No Parent	al Status:	One-Parent Two-Par	rent		
			One-Parent Two-Par	rent		
No. Persons: In Fam	ily No. (	Children: In Fa	mily		d to continu	e use of grant funding.
No. Persons: In Fam Diller-Odell Little Gri Please select the best	ily No. ( ffins preschool is  choice for the follo	Children: In Fa a state grant-fu owing based on	nmily unded program. The follo n primary adult(s) in the h	wing information is needed ome.		
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No. Persons: In Fam  Diller-Odell Little Gri Please select the best of  First & Last Names  Educ Level  COL=Some College, GT	ffins preschool is choice for the follows:  (G9=9th grade or les G=College Degree/T	Children: In Fa a state grant-fu owing based on s, G10=10 <sup>th</sup> Grad Training Cert., A=	amily unded program. The follow primary adult(s) in the h  Birthday/ le, G11=11 <sup>th</sup> grade, G12=12 <sup>th</sup> *Associates Degree, B=Bache	wing information is needed ome.  Soc Sec # Grade, HSG=High School Grad	 de, GED=Gen ree)	Sex F M eral Education Diploma,
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HEALTH CARE/INSU		INFOR	EMATION:	
Does Child have an Education		•	•	
Diagnosed By:			Date of Diagnosis:	
			o is the provider:	
Does child have special needs	or health	problems		
Referred to program by other				
Any specific family need or cr	isis? Y	Yes No	o Describe:	
ALLERGIES and MED Note: Medication must be su, out the authorization for self	ICAL IS pplied by p	SSUES: parent(s)/ ration of t	guardian(s) and sent in the original container that details doctor's orders. Parent mus medications at school and turn return to office (the doctor must sign this form) before ma, a separate form will need to be filled out after the start of school.	
(Please circle Yes or No to the				
Chicken Pox	yes	no	Date	
Bee/wasp Sting Allergy	yes	no	Medication	
Asthma	yes	no	Medication_	
Medicine/Drugs	yes	no	Medication	
Food AllergiesOther Allergies				
Is student currently taking	medicatio	on/drug?	If yes, what kind?	
Does student have epilepsy	or other	seizure	disorder? Yes No	
_			ng impairment, or health (physical or emotional) or behavioral	

Oo you have	other children in you		-		
ast name				Grade & School (if attending)	
ograms m	ATION: I certify ay be subject to le	that this information	is true. If any part iderstand that the info	s false, my participation in this school dirmation in this application will be held in l business hours.	strict
gnature_				Date	
ease Note:	A copy of the <u>child'</u>	's birth certificate and <u>i</u>	nmunizations record wi	ill be needed prior to the start of preschool.	
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