Little
# Griffins
Preschool 2022~2023 Application

***Preschool program for Diller-Odell Children ages 4 and 5.***

**CHILD INFORMATION:**

*Child's Legal Name*: **Last**_____________________________ **First**________________________________

*Race* Black White Native American Asian Pacific Islander

*Child's SS #*______-______-______ *Sex*: **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 #* Cell Home (________) _________ - __________

*Second Contact #* **Cell Home** (________) _________ - __________

*Place of Work*:__________________________________________________________ *Contact#*______________________________

*Foster Parent:* **Yes No** *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** ___/___/___ **Soc Sec #** ______-_____-______ **Sex** F M

**Educ 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)

**Empl 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

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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?* **Y**es **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) |
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**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.***