

# Little Griffins

Preschool 2021-2022 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-Salvador, GU-Guatemala, MX-Mexico, PH-Philippines, PR-Puerto Rico, US-United States, 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: **One-Parent** **Two-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=9<sup>th</sup> grade or less, G10=10<sup>th</sup> Grade, G11=11<sup>th</sup> grade, G12=12<sup>th</sup> 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)

Race Black White Native American Asian Pacific Islander Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

English Prof \_\_\_\_\_ (O=None, 1-Poor, 2-Moderate, 3-Proficient)

Nationality \_\_\_\_\_ (El-Salvador, GU-Guatemala, MX-Mexico, PH-Philippines, PR-Puerto Rico, US-United States, 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**

Educ Level \_\_\_\_\_ (G9=9<sup>th</sup> grade or less, G10=10<sup>th</sup> Grade, G11=11<sup>th</sup> grade, G12=12<sup>th</sup> 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)? Yes No Suspected

Describe \_\_\_\_\_

Diagnosed By: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Is the child receiving services? Yes No Who is the provider: \_\_\_\_\_

Does child have special needs or health problems? Yes No

Describe: \_\_\_\_\_

Referred to program by other agency/professional? Yes No By Whom & Why \_\_\_\_\_

Any specific family need or crisis? Yes No 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.*

