

STUDENT APPLICATION FOR ADMISSION – PRESCHOOL

Please type or print. All information must be provided for application to be considered.

Father's (guardian's) Name

Mother's (guardian's) Name

Student's Full Legal Name

Date of Birth

What are your expectations regarding your child's preschool experiences this year? _____

Does he/she have any individual needs of which the school should be aware? _____

Do you have any concerns regarding your child's individual needs? _____

Has your child attended or is currently attending preschool or daycare? If so, where and for how long? _____

Does your child have any specific fears? _____

At what age was your child toilet trained? _____

Does your child have difficulty separating from you? _____

What are the most significant conflicts or issues between you and your child? _____

What form of discipline do you use in dealing with your child? _____

How does he/she generally respond? _____

Has the family/child been recommended for or participated in any counseling? Please explain. _____

Can your child use the toilet without help consistently? Yes No

If no, do you feel he/she will be receptive to the routine of the school environment? _____

Is any language other than English used in the home? _____

Is there any significant history in the pregnancy or delivery of your child? (This information can alert us to developmental factors.)

Yes No If yes please explain _____

Does your child have frequent colds or earaches? _____

Check any of the following characteristics that most often describes your child:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Thoughtful | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Even tempered | <input type="checkbox"/> Alert |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Destructive | <input type="checkbox"/> Courageous |
| <input type="checkbox"/> Sulks | <input type="checkbox"/> Stammers/stutters | <input type="checkbox"/> Aloof |
| <input type="checkbox"/> Listless | <input type="checkbox"/> Daydreams | <input type="checkbox"/> Cheerful |
| <input type="checkbox"/> Orderly | <input type="checkbox"/> High strung | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Restless | <input type="checkbox"/> Calm |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Sharing |
| <input type="checkbox"/> Breath holding | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Follower | <input type="checkbox"/> Talkative | <input type="checkbox"/> Assertive |
| <input type="checkbox"/> Helpful | <input type="checkbox"/> Honest | <input type="checkbox"/> Compulsive |

Please check below the days on which you would like your child to attend and the pick-up time you prefer.

Monday Tuesday Wednesday Thursday Friday
 12:00 PM 2:35 PM

EMERGENCY MEDICAL FORM

PIONEER VALLEY CHRISTIAN SCHOOL, SPRINGFIELD, MASSACHUSETTS

Please complete the following information and return it to the school with your application material.

Name _____

Address _____

Telephone _____ Date of Birth ____/____/____ Grade _____

Mother _____ Business Telephone _____

Cellular Telephone _____

Father _____ Business Telephone _____

Cellular Telephone _____

Guardian _____ Business Telephone _____

Cellular Telephone _____

Student resides with (please check only one): Mother Father Both Other

If parent or guardian cannot be reached in an emergency, list names of individuals we may call.

Name _____ Daytime Telephone _____

Cellular Telephone _____

Name _____ Daytime Telephone _____

Cellular Telephone _____

Name _____ Daytime Telephone _____

Cellular Telephone _____

Student's Physician _____ Telephone _____

Hospital preference _____

Has student been seen by his/her physician in the last two years? No Yes Date _____

I hereby authorize you to call my child's pediatrician if I cannot be reached and such a call is deemed necessary. Additionally, I give permission to school personnel to treat and/or transport in the event of an emergency.

Is your child covered by health insurance? Yes No

Please submit a copy of your child's insurance card with this form.

Student's health insurance carrier _____ Policy # _____

Signature of Parent/Guardian _____ Date _____

.....
I give permission to the school nurse and/or designated school personnel to administer the following:

Acetaminophen (Tylenol) Antacids Benadryl Ibuprofen (Advil)

Antibiotic Ointment Hydrocortisone Cream All of the above Non of the above

Name of medicines taken on a regular basis and for what purpose _____

Student is allergic to: _____

Signature of Parent/Guardian _____ Date _____

ANNUAL STUDENT HEALTH SERVICES REPORT

Does student have any chronic health conditions, please list. _____

Does student have difficulty concentrating? Yes No

If yes, please explain _____

Restrictions: Classroom _____ Physical Education _____

Are allergy injections being administered? Yes No

Does the student have an Epipen prescription? Yes No

Vision: Known problem: _____

Glasses Contact Lenses

Preferential seating needed? Yes No

Hearing: Known problem: _____

Frequent ear infections Tubes

Preferential seating needed? Yes No

Scoliosis Screening: Known problem: _____

Any illnesses, injuries, or surgery? _____

Any additional information of which the school should be aware: _____

I give permission to the school to share this information with the appropriate school personnel.

Signature of Parent/Guardian _____ Date _____

Please be aware if your child plans on playing a school sport, they must have a current physical sports exam on file at the school. The form must be signed and dated within thirteen months of the particular athletic season.

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth _____

Medical History

Pertinent Family History

Current Health Issues

- Y N**
- Allergies – Please list. Medications _____ Food _____ Other _____
 History of Anaphylaxis to _____ Epi-Pen® Yes No
- Asthma – Asthma Action Plan Yes No (If yes, please attach.)
- Diabetes Type I Type II
- Seizure disorder _____
- Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) – Please circle those administered in school; a separate medication order form is needed for each medication administered in school. _____

Physical Examination

Date of Examination _____

Height _____ (____%) Weight _____ (____%) BMI _____ (____%) BP _____

(Check if normal; if abnormal, please describe.)

- | | | |
|--|--|--|
| <input type="checkbox"/> General _____ | <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Neurologic _____ |
| <input type="checkbox"/> HEENT _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ | |

Screening

- | | | |
|---|--|--|
| Vision: Right Eye (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> | Hearing: Right Ear (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> | Postural Screening (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> |
| Left Eye (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> | Left Ear (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> | (Scoliosis/Kyphosis/Lordosis) |
| Stereopsis (Pass) <input type="checkbox"/> (Fail) <input type="checkbox"/> | | |

Laboratory Results Lead _____ Date _____ Other _____

Examination Normal

Targeted TB Skin Testing Low risk (no PPD done)

Med-to-High risk (exposure to TB; born/lived/travel to TB endemic countries; medical risk factors)

Date of PPD _____ Results _____ mm

Referred for evaluation to _____

This student has the following problem(s) that may impact his/her educational experience (check all that apply).

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Fine/Gross Motor Deficit |
| <input type="checkbox"/> Emotional/Social | <input type="checkbox"/> Behavior | <input type="checkbox"/> Other | |

Comments/Recommendations _____

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions. _____

Y N Immunizations are complete. If no, give reason. _____

Signature of Examiner (Circle: MD, DO, NP, PA) _____ Date _____

Group Practice _____ Telephone _____ Please print name of Examiner. _____

Address _____ City _____ State _____ Zip Code _____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____ Date of Birth: ____ / ____ / ____ Sex femalemale

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type	
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella	1		
	2			2		
	3		Varicella <small>(Var)</small>	1		
	4			2		
	5			Hepatitis A (HepA)	1	
	6				2	
	7					
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide <small>(PPV23)</small>	1		
	2			2		
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
Pneumococcal Conjugate (PCV7)	1			3		
	2		Other			
	3					
	4					

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles			
Mumps			
Rubella			
Varicella*			
Hepatitis B			
* Must also check <i>Chickenpox History</i> box at right.			

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on <ul style="list-style-type: none"> physician interpretation of parent/guardian description of chickenpox, physical diagnosis of chickenpox, or serologic proof of immunity.

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (*please print*) _____ Date _____

Signature _____

Facility Name _____ Telephone _____