

# Pre-School Registration Card

2022-23 School Year

Circle One	
3K	4K

Name of Child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Are you Catholic? \_\_\_\_Yes \_\_\_\_No  
Which parish do you belong? \_\_\_\_\_  
If not Catholic, which religion/church? \_\_\_\_\_  
 Check box if referred by OLL family: Name \_\_\_\_\_

## Please circle (below) all that apply:

Caucasian Native Pacific Islander Latino African American Asian Native American (tribe) \_\_\_\_\_

The Diocese of Superior asks for this information in the yearly Annual Report.

Please complete the entire form.

**Father:** Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Religion \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

**Mother:** Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Religion \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

### Alternate Contact and/or Pick-up Person

Name	Relationship	Phone Number

Name of individuals who should have NO contact with child \_\_\_\_\_

Arrival time for Preschool is between 7:40 and 8:00 am. After Care starts at 3:00 pm.

My child is registering for: *				
Monday	Tuesday	Wednesday	Thursday	Friday
Full Half Day	Full Half Day	Full Half Day	Full Half Day	Full Half Day

Arrival Time \_\_\_\_\_ Departure Time \_\_\_\_\_

\*full day students will be given preference over half day students



## Bingo

Weekly Bingo is held at OLL and run by the school once per month. It is very important to the school that we have enough help when it is the school's turn so things run efficiently. A yearly schedule will be developed in late August.

Please indicate any or all "yes" options to volunteer at bingo.

\_\_\_ Yes, our family would love to volunteer to help at bingo, please put us on the schedule.

\_\_\_ Yes, put our family on the sub list.

**Unusual health conditions?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, complete: Diabetes \_\_\_\_\_ Heart \_\_\_\_\_ Convulsive Seizure \_\_\_\_\_ Epi Pen \_\_\_\_\_

Other: \_\_\_\_\_

**Food or Airborn Allergies:** \_\_\_\_\_ Allergic Reaction: Yes \_\_\_\_\_ No \_\_\_\_\_

Allergy Plan for Staff: \_\_\_\_\_

**Current Medication:** \_\_\_\_\_

*My child will need medication during school hours:* No \_\_\_\_\_ Yes \_\_\_\_\_ (Medicine form needed)

**Family Doctor:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

If emergency treatment is required and the parents/guardians cannot be reached immediately, may the school authorities use their own judgment in calling the doctor indicated above or 911? This will include getting the student to the hospital if necessary.

Check \_\_\_\_\_ Yes

\_\_\_\_\_ No. If NO, what do parents want? \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_