Pre-Kindergarten Registration
Morrisville-Eaton Central School District
P.O. Box 990, Morrisville, NY 13408

Student Name:________________________________ **Lineage**:____________
First Middle Last Jr., III, etc.

Gender: M / F

Ethnicity:
Select all that apply:
- o White
- o Black/African American
- o Asian
- o American Indian/Alaskan Native
- o Native Hawaiian/Other Pacific Islander

Race:
Student Is:
- o Hispanic/Latino (Spanish origin)
- o Not Hispanic/Latino

Date of Birth:__________________
month / day / year

Place of Birth:_________________
city and state

Language Spoken In Student's Home/Residence: ____________________________

Name of Parents/Legal Guardian(s):____

____

911 Physical Address:
____
____

Mailing address (if different from physical):
____
____

Student lives with:
- o both parents
- o his/her mother
- o his/her father
- o his/her mother & step-father
- o his/her father & step-mother
- o his/her grandparents
- o other:________________________

Custody types:
- o sole
- o joint
- o 50/50
- o temporary
- o foster
- o visitation
- o guardian

The following questions address the McKinney/Vento Act. The answers to this residency information will help determine the services the student may be eligible to receive and will remain confidential.

Is your current address temporary? ○ Yes ○ No

If yes, is this temporary arrangement due to loss of housing or economic hardship? ○ Yes ○ No

Is this (circle one): a motel a shelter a relative's house a campground other _________________

Contact Information

(Adults with whom the child lives)

Parent/Guardian (Primary):

Name: ____________________ Relation to Student: ____________________

Home Phone: ____________ Cell Phone: ____________ Email: ____________________

Employer: ____________________ Work Phone: ____________ Ext: ________

Parent/Guardian:

Name: ____________________ Relation to Student: ____________________

Home Phone: ____________ Cell Phone: ____________ Email: ____________________

Employer: ____________________ Work Phone: ____________ Ext: ________

Contact Information

(Parent information if separated/divorced)

Contact 1:

Name: ____________________ Relation to Student: ____________________

Home Phone: ____________ Cell Phone: ____________ Email: ____________________

Employer: ____________________ Work Phone: ____________

Receives Mailings: ____________ Can Pick Student Up From School: ____________
Yes/No Yes/No

Mailing Address: ____

Emergency Contact Information

(To be contacted in an emergency if we are unable to reach Primary)

Name: ____________________ Relation to Student: ____________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

911 Address: ____

Family Composition

ALL other children (under the age of 21) **living in the same household:**

Name	Date of Birth	Age	Grade	Male/Female

ALL adults living in the same household and Income

Name	Relation to student

Previous Education Information

Did they attend any pre-school program(s), such as Head Start, a nursery school, etc.? o Yes o No

If yes, please list the name(s) of the program(s) and dates attended: ______________________________

____

Has the student ever received
- Occupational Therapy o Yes o No
- Physical Therapy o Yes o No
- Speech o Yes o No
- Other o Yes o No

If other please explain: ____

____

____

Health Information

Be sure to provide the school with a copy of the child's most current physical and immunization record.

Child's Physician: ____________________________ Physician's Phone: ____________________________

Date of last physical: __________________________

Birth History	
○ Full term ○ Premature at ____ weeks	Complications:

Check all that apply:					
	Currently has	**Previously had**		**Currently has**	**Previously had**
Allergies	○	○	Behavior disorder	○	○
Blood disorder	○	○	Diabetes	○	○
Dental problems	○	○	Ear tubes	○	○
Epilepsy	○	○	Headaches	○	○
Heart condition	○	○	Heart murmur	○	○
Nightmares	○	○	Nosebleeds	○	○
Seizures	○	○	Other __________	○	○

Does your child have:	Activity restrictions ○ Yes ○ No	If Yes, List:
Has your child had:	Any hospitalizations: ○ Yes ○ No	If Yes, List:
	Any significant accidents/injuries: ○ Yes ○ No	If Yes, List:

Vision	Difficulty seeing? ○ Yes ○ No	Does your child wear glasses? ○ Yes ○ No
	Has your child had a vision exam? ○ Yes ○ No	If yes, when, with whom and what were the results?
Hearing	Difficulty hearing? ○ Yes ○ No	
	Has your child had a hearing exam? ○ Yes ○ No	If yes, when, with whom and what were the results?

Medication	
Is your child currently on any medication? ○ Yes ○ No (If yes, please specify below)	
Name of medication:	Reason for medication:
Prescribed by:	Date prescribed:
Time medication is given:	

Are there any other issues you feel the nurse should be aware of: ____

____

____

By signing this form I am verifying that all of the information is accurate.

______________________________	______________________________	__________________
Print Name	Signature	Date

For Office Use Only:

Student Number: ____________________ Homeroom: ___________________________

Registration date: ___________________ Attendance date: _______________________

Documents required prior to starting school:
- o Parent/Guardian Photo Identification
- o Child's Birth Certificate
- o Court Documents (if applicable)
- o Immunization Records/ Current Physical/ Dental Exam (requested)
- o Academic Records
- o Proof of Residence (copy of utility bill, lease agreement, something you have received in mail)

Transportation: o parent/guardian
o school bus AM - ________ Noon - ___________ PM - _______

Enrollment Type:

- 0011 - Pre-school Enrollment
  - 902 Universal Pre-K Program
  - 1309 Universal Pre-K: District operated
- 0011 - Pre-school Enrollment
  - 990 Other Pre-K
- 0011 – UPK-Universal Pre-K (0666)
  - 990-Other Pre-K