CLAYMONT PRESCHOOL at ST. MARK
601 Claymont Drive
Ballwin, MO 63011
636-386-5437

REGISTRATION FORM

Circle one:
I **do** or **do not** give permission for CPSM to include my child's information in the class roster.

Circle one:
I **do** or **do not** give permission for CPSM to release my child's photo for St. Mark related website.

Child's Name _____ Date of Birth _____

Address _____
Street City Zip

Primary Phone (____)_____ Subdivision _____

E-mail address_____ School District _____

Church _____ Child's Gender _____

Parent's Name _____ Occupation_____

Employer _____ Secondary Phone (____) _____

Parent's Name _____ Occupation _____

Employer _____ Other Phone (____) _____

Names & ages of other children in family _____

_____

How did you hear about Claymont Preschool at St. Mark? _____

Prior school attended _____ How long and how many days a week? _____

Does your child have any food or other allergies, or special medical conditions, including chronic health problems?
CHECK PREFERENCE:

2's	3's	Pre-K
# of days _____	3-day (M/W/F) _____	5-day _____
		4-day (M-Th) _____
Day/s (M-F) _____	2-day (T/Th) _____	3-day (M-W) _____

Enrollment in the programs of Claymont Preschool at St. Mark is open to all persons regardless of their religious affiliation, race, color, national or ethnic origin. Classes may be changed, cancelled or reconfigured according to enrollment.

I understand that the $90.00 enrollment fee is non-refundable except for an "out-of-the-area" move before school starts.

Signed _____ Date_____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME Claymont Preschool at St. Mark	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

Claymont Preschool at St. Mark

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS

A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE	DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

CHILD'S NAME	BIRTHDATE

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

INCLUDE FOOD AND PEANUT ALLERGIES _____

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER