

2020-2021 STUDENT APPLICATION

Revised 6/2020



Child's name Sample only- call for a tour 1st.

Last

First

Gender: Female Male Date of Birth _____

Address _____ Home Ph. _____
Street City Zip

Father's name _____ Address _____
Last First

email _____ Cell Phone _____

Employment _____ Work Phone _____
Employer Occupation

Mother's name _____ Address _____
Last First

email _____ Cell Phone _____

Employment _____ Work Phone _____
Employer Occupation

Does child live with both parents at all times? Yes No If no, with whom? _____

Who is legally responsible for or has legal custody of child? _____

What is the primary language spoken at home? _____

List other members of household. (This information is helpful to teacher when relating to child.)

Name _____ Relationship _____ Age _____

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Please list family members who have attended MCC Preschool and the year(s) attended:

Are you or your extended family current and active members of Makiki Christian Church? Yes No

Do you attend church? No; Yes If Yes, which church? _____ Religious Preference _____

How did you hear about Makiki Christian Church Preschool? _____

Do you plan to have your child continue at Makiki Christian Church Preschool until your child graduates from preschool? Yes No. If no, what are your plans for your child? _____

Note: Priority will go to children who will continue at Makiki Christian Church Preschool

Current child care arrangements _____ Previous preschools attended _____

Preferred date of entry: Fall/Year _____ Spring/Year _____ Summer/Year _____
(Please list your 1st choice; 2nd choice; etc.)

Parent Signature _____ Date _____

For Office use only Application: Registration: Comp fee:
Deposit: Start date:

At what age did your child begin to crawl? _____

Has your child ever been seriously or severely ill or injured? No; Yes; please explain: _____

Does your child have frequent colds? No; Yes; How many in the last year? _____

Does your child have any allergies? No; Yes; Specify food, medicine, etc. _____

Is this condition life threatening? No; Yes; Any physical limitations? _____

Does your child have shortness of breath or difficulty in breathing? No; Yes Comments _____

What is your overall evaluation of your child's health? _____

Does your child have any medical or educational diagnosis? _____

Sleeping Habits

What time does your child awake in the morning? _____ What time is bedtime? _____

Does your child nap during the day? Yes No At what time? _____ For how long? _____

What is your bedtime routine? _____

Does your child sleep well? _____

Eating Habits

Type of Foods

When is your normal meal time?

Diet pattern: Breakfast _____

Lunch _____

Dinner _____

Any strong food dislikes? _____ Any eating problems? _____

Toilet Training

When did toilet training start? _____ month? Is your child completely toilet trained? Yes No

Does your child have any toileting problems? _____

What is your child's word for bowel movement? _____ Urination? _____

Is your child's bowel movement regular? Yes No Usual time? _____

Personal History

What language(s) is spoken in the home? _____ Does he express his needs and wants? _____

Describe your child's personality? _____

How does your child get along with parents, siblings, other children? _____

Describe any previous group experiences: _____

Describe any behavioral problems, fears: _____

How is your child disciplined at home? _____

What are your goals and expectations in sending your child to preschool? _____