hamilton county esc
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Preschool Program Student Registration Form

Child's Legal Name: _____
(As it appears on Birth Certificate) First Middle Last

Child's Home Address: _____
Street Address

_____
City State Zip Code

Child's Home Phone: (_____)_____-_____ District student lives in:_____

Primary Email Address of Parent or Guardian:_____

Gender: Male ◯ Female ◯

Ethnicity: Asian/Pacific Islander ◯ Black/Non-Hispanic ◯ Hispanic ◯
American Indian/Alaskan ◯ Multi-Racial ◯ White/Non-Hispanic ◯

Child's Date of Birth:_____/_____/ _____(MM/DD/YYYY) Place of Birth:_____
City & State or County & State as on Birth Certificate

Did a sibling attend the early childhood program? Yes ◯ No ◯

If yes, name of sibling and year:_____

Primary Language Spoken in Child's Home:_____

Previous School Attended (if applicable):_____

Has the Child had previous intervention services? Yes ◯ No ◯ If yes, describe and provide location below:

_____ _____
Description of Service Location

_____ _____
Description of Service Location

Name of Natural or Adoptive Mother:

_____
First Middle Last

Name of Natural or Adoptive Father:

_____
First Middle Last

With whom does the Child reside?

Name:_____
First Middle Last

Relationship: _____

Occupation: _____

Address: _____
(If different from Child's Address) Street

_____
City State Zip Code

Bus. Phone: _(_____)_____-_____ ext._____

Name:_____
First Middle Last

Relationship: _____

Occupation: _____

Address: _____
(If different from Child's Address) Street

_____
City State Zip Code

Bus. Phone: _(_____)_____-_____ ext._____

Parents' Marital Status: Married ◯ Single ◯ Separated ◯ Divorced ◯

Sibling Name	Relationship	Age	Lives with Student?
_____	_____	_____	Yes ◯ No ◯
_____	_____	_____	Yes ◯ No ◯
_____	_____	_____	Yes ◯ No ◯

Emergency Information

Adults to whom the Child may be released in an emergency situation, if the Child is ill or needs medical attention:

Name	Relationship	Phone Number
_____	_____	_(_____)_____-_____ ext._____
_____	_____	_(_____)_____-_____ ext._____

Family Physician: _____ Phone: _(_____)_____-_____

Family Dentist: _____ Phone: _(_____)_____-_____

Please list any allergies, medications taken regularly, health impairments, or handicaps, to which school personnel or a physician giving emergency medical treatment should be alerted:

_____

_____

_____

My signature below certifies that all the information given on this registration form is true and accurate to the best of my knowledge.

Signature:_____ Date:_____

Please email this completed Registration form to
meghan.ott@hcesc.org
If you have any questions about the program please email
Jenny.griffith@hcesc.org

OFFICE USE ONLY: FOR PROGRAM SUPERVISOR COMPLETION ONLY

First Day in Classroom _____

Session A P