

Our Lady of Hope Parish
St. Gabriel of the Sorrowful Virgin Site
5200 Greenridge Drive
Pittsburgh, PA 15236

2021-2022 Early Childhood/Preschool Program Registration

Childs name: _____
(First) (Middle) (Last)

Nickname: _____ Birth Date: _____ Gender: M ___ F ___

Address: _____

Parish Membership: Our Lady of Hope _____ Other(list) _____

Parent/Guardian Name#1: _____

Cell Phone: _____ Occupation: _____

Email address: _____

Parent/Guardian Name#2: _____

Cell Phone: _____ Occupation: _____

Email: _____

****Email will be used for preschool communication please list at least one that is checked regularly****

Please mark 1st and 2nd choice for which session you would like to register your child:

3/4 yr T/TH	4/5 yr M/W/F
_____ (8:45-11:00)	_____ (8:30-11:00)
_____ (12:45-3:00)	_____ (12:30-3:00)

4/5 yr M/T/W/Th/F
_____ (afternoon)

In case of Emergency please designate, in order, who should be contacted. Please list at least 3. (If there are specific custody arrangements, please inform staff and submit copies of relevant court documents)

	Name	Phone Number	Relationship to child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

For your child's protection he/she will not be released to any unauthorized person. Please list the people you permit your child to meet at dismissal time.

	Name	Phone Number	Relationship to child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

STAFF USE ONLY:

Registration fee enclosed: yes _____ no _____ ck # _____ cash _____

Copy of immunization record attached: yes _____ no _____

RELEASES

Throughout the school year, pictures are taken of the children as they engage in normal daily activities. The pictures are used at meetings, in conjunction with projects, for bulletin boards and for portfolios. Occasionally photographs of the children in our program are requested for parish and/or Diocesan communications. If we do not have your signature, please understand we will not be able to include your child's picture in our projects.

I permit _____ I do not permit _____ my child to be included when pictures are taken during preschool sessions and activities.

Parent/guardian signature: _____ Date: _____

I permit _____ I do not permit _____ my child to be included in the class roster for his/her preschool class to be distributed to that group.

Parent/guardian signature: _____ Date: _____

****Due to the pandemic we are not offering the following part our program at this time, however you may complete it in case things change ****

We are proud that family involvement is an integral component to our program and has proven to be a very successful and dynamic one. Through generous and enriching parent/family participation, our young children, their families, and our staff have benefited greatly.

If you would consider assisting us in this special enhancement of our program, through an interest, hobby, collection, career, or other, please complete the information below. (Ex. Police officer, dentist etc.)

Family member's name: _____

Would like to share:

Hobby/skill: _____

Collection: _____

Pet: _____

Thank you in advance for your contribution!

Information about your child

Any known allergies: yes _____ no _____

If yes, please describe:

Has your child attended library story time, play group or other child's activity group?

Does your child have playmates his/her own age? _____

Does your child take medication on a regular basis? If so please describe:

Does your child have any physical characteristics of which we should be familiar?

Does your child have any fears which may affect participation in the group?

Does your child currently receive any services outside of school? (DART, TSS, Speech)

Please list all family members and any pets in household. We refer to this during discussions for prompting ideas and language development, as well as spelling for projects.

Please list any additional comments or concerns:

**EARLY CHILDHOOD/PRESCHOOL PROGRAM
OUR LADY OF HOPE PARISH - ST. GABRIEL SITE MEDICAL SHEET**

Student's Name Last: _____ First: _____ Middle: _____

Student's Physician _____ Phone # _____

In case of emergency, should student's physician be contacted if parent is unavailable? Yes No

Current Medications and dosages _____

Please describe the reaction and treatment if your child has a severe allergic reaction to the following:

Bee or other stinging insect: _____

Reaction _____ Treatment _____

Food allergies: Type of food: (e.g. nuts) _____

Reaction _____ Treatment _____

Other severe Reaction _____ Treatment _____

I give consent for my child to receive minor first aid (band aid, ice, etc.) Yes ___ No ___

*Please initial here if OK to give Benadryl in event of a reaction. Yes ___ No ___

If your child has a severe allergy requiring the use of an EpiPen, you must submit a written physician's order, parental or guardian's written consent and the medication for treatment following a severe allergic reaction.

In an emergency, the E.M.S. will take the student to the nearest hospital. Every effort will be made to contact the parent/guardian prior to transport. If you prefer other arrangements, please state: _____

No treatment except lifesaving procedures will be given at the hospital without consent of parent, authorized relative or guardian. The staff must also be made aware of any changes in health conditions, or newly diagnosed conditions listed above, as well as any changes in addresses, phone numbers or emergency contacts.

Student medical records, are considered educational records and will be shared with staff who have a legitimate educational interest in the information and a need to know medical information to protect the safety and health of the student. Once provided, specific parental consent will not be sought to share information on a need to know basis. Parental requests to maintain the confidentiality of specific medical information must be made in writing.

Parent/Guardian Signature _____ Date: _____