CHILD APPLICATION ($40 application fee due when turned in) Date: _____
(Please Print Legibly)

HOLY SPIRIT PRESCHOOL
3930 Parish Ave.
Fremont, CA 94536
hspreschool@csdo.org

_____ _____ Catholic ____ Non-Catholic ____
Family Name (Last name) Child's Date of Birth
_____Male ___Female ___
Child's Name (Last) (First) (Middle)
_____
Home Address City State Zip
_____ _____
Home Phone Cell Phone
_____
E-Mail Address

Has your child attended preschool / daycare previously? Y or N If so, list below (more than 1, list on back):
_____ _____ _____
School/Daycare City Phone How long?
==========
Other Siblings (Name & Date of birth) _____
Siblings at Holy Spirit Elementary (Currently or previously)____Y ____N If yes, what grade?_____

Father _____ _____ _____ _____
Last Name First Name Place of Birth Religion
_____ _____ _____ Y___N___
Occupation Employer Business Phone U.S. Citizen
Mother _____ _____ _____ _____
Last Name First Name Place of Birth Religion
_____ _____ _____ Y___N___
Occupation Employer Business Phone U.S. Citizen

Check all home conditions that apply:
Traditional ___ Divorced ___Father Deceased ___ Mother Deceased___ Foster Home __Mixed Religion ___
Father Separated __ Father Remarried __ Mother Separated __ Mother Remarried__

Child lives with: Both Parents _____ Grandparents _____ Mother ____ Father ____ Guardian ____ Other____

Race (Optional) Asian ___ Black/African American ___ Hispanic ___ Native American/Alaskan ___
Pacific Islander/Native Hawaiian ___ White / Caucasian ___ Other ___

Are you registered at your Parish: Yes ____ No ____ _____ _____
Name of your parish Envelope #

For which program are you applying for: (All programs are Monday – Friday)
____Caterpillar prgm: 3 years old as of Sept. 1st

____Butterfly prgm: 4 years old as of Sept. 1st

Are you interested in our Summer Program? Yes No (If applying for 3's, your child must be fully potty trained.)

Do you intend to send your child to Holy Spirit Elementary? Y / N (No guarantees, separate enrollment)

Are you willing to volunteer a minimum of 5 hours per school year? Yes No

HOLY SPIRIT PRESCHOOL
PRE-ADMISSION HEALTH/DEVELOPMENT HISTORY - PARENT'S REPORT

Name _____ Birthdate _____

Indicate age your child: walked unassisted _____spoke words _____ spoke in sentences _____

Reason for requesting Preschool placement _____

Would you be able to volunteer in the classroom (5 mandatory hours per school year)? _____

Sleeping Habits

- What time does your child get up in the morning? _____ Go to bed? _____
- Does your child nap in the afternoon? _____ Does your child have frequent nightmares?_____

Toilet Habits

- Is your child fully potty trained? _____ Does your child wear Pull-Ups?_____
- What words does your child say for Urination_____ Bowel Movement _____
- Does your child have a history of Bladder infections _____ Diarrhea or Constipation_____

Does your child suck his/her thumb during the day or have other pacifying routines? _____
_____

Social Setting

Tell us something special about your child. _____
_____

Briefly describe your child's relationship with his/her brothers and sisters _____
_____

Group play experience (if any) _____
_____

Are there other adults living in the home besides the parents? _____
_____

Does your child have problems in being separated from you? _____
_____

If your child is adopted, does he/she know it? _____
_____

What do you consider to be your child's strengths and weaknesses? _____
_____

What skills and/or experience do you feel are important for your child to receive in preschool ?
_____
_____

What discipline techniques do you use at home with your child? _____
Does your child eat independently?_____
Do you feel that your son/daughter has any special problems/fears of adjustment to friends, to school or to family that should be brought to the attention of your physician or school personnel? Y / N
Comments: _____

COMPLETE OTHER SIDE

Language

What is your child's primary language spoken in the home? _____

Does your child speak more than one (1) language fluently? Y / N.
If yes, what language(s)? _____

Medical History to be completed by Parent

Health History (check the conditions where appropriate)

____ Allergy to Medications
____ Asthma
____ Appendectomy
____ Cerebral Palsy
____ Chicken Pox
____ Concussion
____ Defective Vision
____ Wears Glasses
____ Diabetes
____ Dizziness/blackouts
____ Ear Trouble
____ Hearing Loss
____ Epilepsy
____ *Other (Please explain in the space below)

___ Frequent Headaches
___ Freq. Leg or Joint Pain
___ Hay Fever
___ Heart Disease
___ Hernia (Rupture)
___ Kidney Disease
___ Lameness
___ Measles (Rubeola)
___ Mumps
___ Nervousness
___ Persistent Cough
___ Poliomyelitis
___ Recurrent Boils

____ Rheumatic Fever
____ Rubella (3 day measles)
____ Scarlet Fever
____ Shortness of Breath
____ Sinus Trouble
____ Speech Difficulty
____ Teeth Problems
____ Tires Easily
____ Tonsillectomy
____ Tuberculosis
____ Whooping Cough
____ Epilepsy
____ Allergy to Foods (List Below)

*Other medical conditions not listed above (birth defects/marks, ear/eye conditions, etc): _____
_____

Does child have frequent colds? Y / N Approximately how many in last year? _____

List any other serious illness, operation or injury and the age when this happened.
_____

List <u>all</u> foods/substances/medications your child is allergic to (be specific): _____
_____
Has your son or daughter had contact with and / or had tuberculosis? Y / N Last contact _____

Has your child ever been advised not to participate in physical activity? Y / N

Is your child now under care for any medical problem? Y / N If so, please specify _____
_____

Does your child take any medication/vitamin/supplement on an ongoing daily basis? Y / N If yes, please explain
_____

What is the plan for your child when he/she becomes ill at school and who should we contact first?
_____

Parent's Signature: _____ Date: _____