REGISTRATION FORM

Enfield Family Resource Center

Child's's Name: _____ **Sex: M ____**
Last First Middle **F ____**

Address: _____ Home Phone: _____

Family Doctor: _____ Phone: _____

Does your child have medical insurance: ____Yes ____No If Yes, Insurance Provider: _____

Verified Date of Birth: _____ Place of Birth: _____

Preschool and/or Kindergarten Experience **Yes ____NO_____** _____
Name of Preschool and/or Kindergarten

LOCAL EMERGENCY NAMES & TELEPHONE NO:
1. _____ Phone: _____

2. _____ Phone: _____

Family Data	Name/Address	Place of Employment & Telephone Number
Father		
Mother		
Step Parent or Guardian		

Child Lives With (circle one): Both Parents Mother Father Guardian

Race/Ethnicity (circle): Caucasian African American Hispanic/Latino Asian Native American Multiracial
Other _____

Name of Brothers/Sisters **Date of Birth** **Grade**
_____
_____
_____
_____
_____

Please share any concerns you have about your child
_____
_____
_____
_____
_____

Please answer all questions:

1. What is the primary language spoken by you or other persons in your home?

_____

2. What is the primary language spoken by your child when he/she is at home?

_____

3. Is your child receiving Birth -3 or preschool special education services?

_____

4. Are you enrolled in the WIC program: _____Yes ____No

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1. Has your child had any illness, injury, or Operations?
specify _____
_____

2. Does your child have any allergies?
_____Yes _____No Please list them:
_____
_____

3. Does your child have a **BEE STING ALLERGY**?
_____Yes _____No
_____

Does your child have any **FOOD/NUT ALLERGY**?
_____Yes _____No
Specify: _____

Is child taking oral or injectable medication for above allergy? _____Yes _____No
Specify _____

4. Does your child take any mediation on a regular basis?
_____Yes _____No
Specify _____

5. Are there any other health problems not already listed that the school should be aware of?
_____
_____
_____