

CITY OF KNOWLEDGE SCHOOL

3285 N. Garey Ave. Pomona, CA 91767

(909) 392-0251

Fax: (909) 622-2219

APPLICATION FOR PRESCHOOL ADMISSION

STUDENT INFORMATION

Student _____
Last First Middle

Address _____ City _____ Zip _____

Phone () _____ Birthday _____ Grade Entering _____

Birthplace _____ Age _____ Sex M F
City State Country

STUDENT DEVELOPMENTAL INFORMATION

Do any of following factors apply in your child's life: absence of father or mother, adoption, in -laws or grandparents in the home, unusual accidents or serious illness, disability, or other?

Comments _____

Does your child have any limitations which would hinder him/her from normal progress in a regular classroom situation? If so explain _____

Has your child ever lived outside the United States? _____

If so, Where? _____ When & for How Long? _____

What is the predominant language in your home? _____

What language is spoken by the father? _____ Mother? _____

List languages in which your child is proficient _____

FAMILY INFORMATION

Father or Legal Guardian _____ Phone () _____

Address _____
Number street city zip

Occupation _____ Employer _____

Address _____ Phone () _____
Number street City zip

Mother's Name _____ Phone() _____

Address _____
Number street City Zip

Occupation _____ Employer _____

Address _____ Phone () _____
Number Street City Zip

Relationship of Parents _____ Married _____ Divorced

Brothers and Sisters (Please list Below)

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENT EXPECTATIONS

What are your expectations for your child's education at this school? _____

What do you feel are the responsibilities of the school? _____

What do you expect from the school in terms of discipline? _____

City of Knowledge School

CHILD'S NAME _____

DATE _____ BIRTHDATE _____

HEALTH HISTORY

History To Be filled out By Parent

Circle Correct Statements and Return to School When Completed

A- PREGNANCY AND BIRTH Circle Correct Answer

- | | | |
|---|----|-----------|
| 1. Did you have an illness during your pregnancy? ----- | No | Yes |
| 2. Did the baby come on time?----- | | Yes No |
| 3. What was the birth weight? ----- | | |
| 4. Did your baby have any trouble starting to breathe ? ----- | No | Yes |
| 5. Did the baby have any trouble while in the hospital? ----- | No | Yes |

B. FEEDING AND DIGESTION

- | | | |
|--|-----|-----|
| 1. Was there severe colic or any unusual feeding problems the first three months?----- | No | Yes |
| 2. Is your child's appetite usually good?----- | Yes | No |
| 3. Is it good now?----- | Yes | No |
| 4. Do any foods disagree with him/her?----- | No | Yes |
| 5. Does he/she often have diarrhea?----- | No | Yes |
| 6. Has constipation ever been much of a problem?----- | No | Yes |
| 7. Does he/she take vitamins with <input type="checkbox"/> Iron? <input type="checkbox"/> fluoride? | | |
| 8. Does your child eat a wide variety of foods?----- | Yes | No |
| 9. Does your child frequently eat clay, paint chips, dirt or any thing else that is not usually considered food----- | No | Yes |
| 10. What type of milk is your drinking?----- | | |

C. FAMILY HISTORY

1. circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters have had:
Tuberculosis, diabetes. Asthma. Heart disease, High blood Pressure, allergy, Seizures. Cancer, Mental illness, Inherited Diseases.
2. Are the child's parents born in good health?----- Yes No
3. Have any of your children died?----- No Yes

D. INFECTIONS. ILLNESSES. MISCELLANEOUS PROBLEMS AND DEVELOPMENT

- | | | |
|---|-----|-----|
| 1. Has your child had as many as three bouts of ear trouble?----- | No | Yes |
| 2. Does he/she usually have more than three colds or throat infections a year with fever? ----- | No | Yes |
| 3. Does he/she have any trouble with urination?----- | No | Yes |
| 4. Has he/she ever had a convulsion?----- | No | Yes |
| 5. Does he/she had any trouble with his/her eyes?----- | No | Yes |
| 6. Does he/she hear well?----- | No | Yes |
| 7. At what age did he/she sit alone?----- | | |
| 8. At what age did he/she walk alone?----- | | |
| 9. Did he/she say any words by the time he/she was 1 1/2 years old?----- | Yes | No |
| 10. Does he/she have any trouble sleeping now?----- | No | Yes |
11. Circle any of the following that your child has had: "Red" or "hard" Measles, Whooping Cough, German or three Day Measles, Serious Accidents, broken bones. Pneumonia, removal of Tonsils and Adenoids,
Other Operations _____
Other Diseases - What? _____

Hospitalization -What? _____

E. ALLERGIES

- | | | |
|--|-----|-----|
| 1. Has he/she ever had eczema or hives?----- | Yes | No |
| 2. Has he/she ever had wheezing or asthma?----- | No | Yes |
| 3. Does he/she tend to have a stuffy nose or constant cold?----- | No | Yes |
| 4. Has he/she had any allergies or reactions to any medicines or injections, immunizations?
----- | No | Yes |

F. EMOTIONAL PROBLEMS

- | | | |
|---|-----|-----|
| 1. Is he/she doing well in school?----- | No | Yes |
| 2. Does he/she get along well with other children?----- | Yes | No |
| 3. Circle any of the following which your child has: Nail Biting, Thumb Sucking, Nightmares. Bad Temper. Irritable, Wets Bed. Won't mind, Cant Toilet Train, speech problems, Breath holding, Jealousy. | | |

Date _____ Parent Signature _____

Authorization for Medication (s) to be taken During School Hours

The following section is to be completed by the PARENT:

School Name **City of Knowledge**

Child's Name _____
Last First Sex Birth date

Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as authorized by me and my physician (see below).

Date Parent/Guardian signature Home phone Emergency

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medicine: _____

Form: _____

Dose: _____

If medicine to be given DAILY, at what time ? _____

If medicine to be given "WHEN NEEDED,"
describe indications: _____

How soon can it be repeated ? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information:

Date _____ Physician's signature _____