



City of Knowledge School

ACCREDITED BY WESTERN ASSOCIATION OF SCHOOLS AND COLLEGES

3285 N. Garey Avenue, Pomona, California 91767 USA Tel (909)392 - 0251 / Fax (909)392 - 0295

PRESCHOOL

APPLICATION FOR ADMISSION

STUDENT INFORMATION

Student _____
Last First Middle

Address _____ City _____ Zip _____

Phone () _____ Birthday _____

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? _____

Are you interested in being an involved parent? If so, how would you like to contribute?



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HEALTH HISTORY

History to be filled out By Parent
Circle Correct Statements and Return to School When Completed

CHILD'S NAME _____

DATE _____ BIRTH DATE _____

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? ----- | <hr/> | |
| 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?----- | <hr/> | |

C. FAMILY HISTORY

- 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.
- Are the child's parents born in good health?----- Yes No
- 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 have 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 _____