Bishop John King Mussio Central Elementary School
Preschool Registration Form

___3 year old (by August 1) *is 5 days per week* _____ I am interested in a half day program _______
___4 year old (by August 1) is *5 days per week* _____

Student Name____
(Last) (First) (Middle)

Address____
(Street) (City) (State) (Zip Code)

Home Phone Number__________________Family E-Mail Address__________________

Birthdate__________________Gender__________________Social Security Number__________________

Religion __________________Student's Parish__________________

Sacraments Received:

Baptism (Church)__________________(City & State)__________________(Date)__________

First Communion (Church)__________________(City & State)__________________(Date)__________

Confirmation (Church)__________________(City & State)__________________(Date)__________

Public School **District** in which student resides__________________

Name of Public School **Building** nearest student's home address__________________

ETHNIC GROUP (Please select only one)

_____*American Indian/Alaskan Native* (person having origins in any of original peoples of N America and maintains cultural identification through tribal affiliation or community recognition

_____*Asian* (person having origins in any one of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)

_____*Hispanic* (persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race)

_____*Black, not Hispanic origin* (a person having origins in any of the Black racial groups of Africa)

_____*Native Hawaiian/Other Pacific Islander* (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island

_____*Multiracial* (a person having origins in two or more racial/ethnic categories)

_____*White, not Hispanic origin* (a person having origins in any of the original peoples of Europe, North Africa or the Middle East

School Previously Attended__________________Dates__________Grade Completed__________

Father's Name__________________Occupation__________________
(Last) (First) (Title)

Religion__________________Parish__________________Employer__________________

Home Phone__________________Cell Phone__________________Work Phone__________________

Mother's Name__________________Occupation__________________
(Last) (First) (Title) (Maiden)

Religion__________________Parish __________________Employer__________________

Home Phone__________________Cell Phone__________________Work Phone__________________

Whom does student live with? (Please circle): Mother & Father, Mother only, Mother and Stepfather, Father only, Father & Stepmother, Guardian

Parent or Guardian Signature______________________________Date__________________

Copies needed for complete registration:

_____Official Birth Certificate

_____Social Security Card

_____Baptism Certificate

_____Immunization Record

_____$50 Registration Fee **for new families to BJKM**

(Over please)

Sibling Information (Please list all siblings in the family)

Name	Age	Grade	School

The following information must be provided if the enrolling student ***lives with*** a guardian or stepparent:

Stepparent
Name____
(Last) (First)

Home Phone____________________ **Work Phone**________________________ **Cell Phone**______________________

Guardian
Name____
(Last) (First)

Home Phone____________________ **Work Phone**________________________ **Cell Phone**______________________

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
____
____
____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with ____________________

Lead Poisoning

☐ Date ____________ Type ☐ C ☐ V Results____________ μg/dL
☐ Date ____________ Type ☐ C ☐ V Results____________ μg/dL

Tuberculin Test

Date____________ Type __________ Results____________

Health History (Serious or chronic illnesses/injuries/surgeries)

____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows
____
____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify
____
____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?
____
____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP