

Eagle Heights Christian School

5600 N Brighton Ave. | Kansas City, MO 64119

Preschool Application Form

Please return this form along with the following:

___ Enrollment Fee (before 3/17 \$125; after 3/17 \$250.00)

___ Copy of Student's Immunization Records

Child's Name (Last, First, Middle, Nickname) Date of Birth Gender
M/F

Address (Street, City, State, Zip Code)

In which program would you like to enroll your child?

___ **K4 Program** – For 4 year olds and young 5 year olds | Must be 4 before August 1

Identifying Information

Father's Name (Last, First) Daytime Phone Number Cell Phone Number

Address (Street, City, State, Zip Code) E-mail Address

Employed By Hours of Employment

Address (Street, City, State, Zip Code) E-mail Address

Mother's Name (Last, First) Daytime Phone Number Cell Phone Number

Address (Street, City, State, Zip Code) E-mail Address

Employed By Hours of Employment

Address (Street, City, State, Zip Code) E-mail Address

Emergency Contact (Other than Parents or Doctor)

Name (Last, First) Daytime Phone Number Cell Phone Number

Address (Street, City, State, Zip Code) Relationship to Child

Authorized Persons to Pick Up Child Other Than Parent

Name (Last, First) Phone Number Relationship to Child

Name (Last, First) Phone Number Relationship to Child

Name (Last, First) Phone Number Relationship to Child

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Sibling Information

____	M/F	____	Yes/No
Name (Last, First)	Gender	Age	Lives with Applicant Child
____	M/F	____	Yes/No
Name (Last, First)	Gender	Age	Lives with Applicant Child
____	M/F	____	Yes/No
Name (Last, First)	Gender	Age	Lives with Applicant Child
____	M/F	____	Yes/No
Name (Last, First)	Gender	Age	Lives with Applicant Child

Please Check All That Apply for Your Child:

___ Lives with both Parents	___ Parents are Divorced	___ Mother Deceased
___ Lives with Mother	___ Parents are Separated	___ Father Deceased
___ Lives with Father	___ Lives with Guardian(s)	___ Other – Indicate Below

Describe any unusual custody situations: _____

Has your child been diagnosed with any of the following?

___ ADD ___ ADHD ___ LD ___ BD ___ Depression

Please describe any special health or learning needs your child has (i.e. allergies): _____

Authorization for Emergency Medical Care

 Physician to be used in any Emergency Telephone Number

 Preferred Hospital to be used in an Emergency Telephone Number

I understand that in the case of an accident or injury to my child, I will be notified immediately. If my child requires emergency medical care, my preferred physician and hospital will be communicated to emergency personnel.

 Parent / Legal Guardian Signature Date

Agreement

When my child is ill, I understand and agree that my child may not be accepted for class. Our Sickness Policy states, "If either a temperature or vomiting occurs within 24 hours of school, your child is **not allowed to come to school.**" We ask that your child be free of both for a 24 hour period.

 Parent / Legal Guardian Signature Date

 Parent / Legal Guardian Signature Date