Acton United Methodist Preschool
Student Information

Student's Name: First Middle Last		
Nickname:	Birthdate:	
Address:		
Primary Contact:	Relationship to Student:	
Phone:	Email:	
Secondary Contact:	Relationship to Student:	
Phone:	Email:	
Name and Age of Siblings:		
School District:	Do you expect to move before school's end: YES NO	
Student's Physician:	Phone:	
Is Student Toilet Trained? YES NO	RIGHT HANDED LEFT HANDED NO PREFERENCE	
List any special fears of student: (thunder, spiders, etc.):		
List anything unusual in health, family situation, or emotional security:		

_____My child has no health problems or physical limitation that will cause him/her a problem at school.

_____My child has the following health problems that may affect him/her during the school day.
(Please check those that apply and explain below)

_____ Asthma	_____ Eye condition, not including glasses
_____ Allergies (please list below)	_____ Heart conditions
_____ Bee sting requiring meds	_____ High blood pressure
_____ Cancer	_____ Kidney problems
_____ Diabetes	_____ Seizure/Epilepsy
_____ Hearing problems	_____ Other (explain below)

PLEASE LIST ANY ALLERGIES OR EXPLAIN ABOVE:

How did you hear about the preschool: