

Child's Personal Record

Child's name _____

Reason for wanting your child enrolled in the *Cougar Preschool Program*: _____

How did you hear about the program? _____

What opportunities has your child had to play with other children? _____

What are your child's favorite toys or play materials? _____

Are there fears that we should be aware of? _____ If so, please describe. _____

What would you like your child to gain from preschool? _____

We want to understand your child so please use the check list to describe his/her personality:

- | | |
|------------------------------------|------------------------------------|
| _____ Calm | _____ Negative |
| _____ Excitable | _____ Cooperative |
| _____ Easily angered | _____ Shy |
| _____ Sensitive | _____ Friendly |
| _____ Happy | _____ Aggressive |
| _____ Fearful | _____ Cries easily |
| _____ Jealous | _____ Possessive |
| _____ Speech Problems | _____ Problems with muscle control |
| _____ Ability to share with others | _____ Talkative |

Other comments that may be helpful to understanding your child: _____

Child's health: (any physical weakness, defect or chronic condition which should be taken into consideration? (Sight, hearing, allergies, etc.) _____

Any home problems which may affect child's behavior? _____

****A medical form is required by the *Cranford Board of Education*. This additional form must be completed by the child's physician and returned before the child enters the program.

Preference of sessions: (please check all that apply)

Fall Session (state year starting) _____
 AM Or PM
 Spring Session (state year starting) _____
 AM Or PM

Date of Application: _____

Date received: _____

Registration confirmed: _____

Medical received: _____

**Application for Registration at the
Cranford Cougar Preschool
Cranford High School
201 West End Place
Cranford, NJ 07016**

Child's name _____ Birthdate _____
Nickname (if any) _____ Sex _____ Age _____
Address _____ Telephone _____

Father's full name _____ Occupation _____
Father's address _____ Telephone _____
Business address _____ Telephone _____
Mother's full name _____ Occupation _____
Mother's address _____ Telephone _____
Business address _____ Telephone _____

Marital Status: Married _____ Widowed _____ Divorced _____ Separated _____ Single _____

Name and relationship of other members in the household: (please list names and ages)

Alternate contact in case of emergency. A local person, relative, other preschool mom or your cell phone is helpful. (List name, relationship, and telephone)

Child's Physician _____ Telephone _____

Does your child have any allergies? _____ If so, please list: _____

Please list all previous group play experiences your child has participated in: _____

Parent signature _____

**CRANFORD PUBLIC SCHOOLS
Cranford, NJ**

MEDICAL ENROLLMENT FORM

Name: _____ Date of Birth : _____

Health Information (to be completed by parents)

Asthma _____ Eczema _____ Meningitis _____ Other _____

Cardiac _____ Hepatitis _____ Pneumonia _____ Lyme _____

Chicken Pox _____ Immune Disorder _____ Rheumatic Fever _____

Bronchitis _____ Tuberculosis _____ Seizure Disorder _____

Allergies (describe) _____

Other: (operations, serious injuries, convulsions etc) _____

List any relevant disability _____

Indicate any vision or hearing difficulty _____

List any medications _____

THIS SECTION TO BE COMPLETED BY THE FAMILY PHYSICIAN ONLY

Immunizations:

1. DPT _____ _____ _____ _____ _____
 Date Date Date Date Date

2. Polio _____ _____ _____ _____
 Date Date Date Date

3. MMR _____ _____
 Date Date

 OR

Measles Vaccine _____ _____
 Date Date

Mumps _____
 Date

Rubella _____
 Date

Name _____

4. Hib Vaccine _____
Date Date Date Date

5. Chickenpox Vaccine _____
Date

6. Hepatitis B Vaccine _____
Date Date Date

7. Influenza Vaccine _____ Pneumococcal Vaccine _____
Date

Date
Mantoux Test _____
Date Results

BCG _____
Date

Physical Examination

Vision : R _____ L _____
Hearing: R _____ L _____

Height _____ Weight _____ BP _____
Ears _____ Eyes _____ Skin _____
Heart _____ Lungs _____ Thyroid _____
Tonsils and Adenoids _____ Hernia _____ Genitals _____
Other Glands _____

General Physical Condition _____

Signature of Physician
day of school)

Date of Exam (within 365 days of the 1st

Health Records Checked by _____ Date _____