



Our Lady of Mercy Catholic School

1730 Link Rd.
Winston-Salem, NC 27103
336.722.7204
www.ourladyofmercyschool.org
A Blue Ribbon School of Excellence for PreK-8th Grade, SACS accredited

PRE-K ADMISSION APPLICATION

2017-2018

Date of Application _____

Date of Enrollment _____

Please complete this application and return it with the following:

- \$75 non-refundable **REGISTRATION FEE.**
- Copy of current **IMMUNIZATION RECORDS**
- \$100 non-refundable **ACCEPTANCE FEE** (Due upon acceptance)
- \$150 non-refundable **CURRICULUM FEE** (Due upon acceptance)
- Copy of **BIRTH CERTIFICATE**
- Copy of **BAPTISMAL CERTIFICATE** (Catholic students)

STUDENT INFORMATION

Sex: M F

Full Name _____ Nickname _____

Last First Middle

Address _____ City _____ State _____ Zip _____

Date of Birth _____ ***MUST BE 4 BY AUG. 31, 2017** Place of Birth _____

Religion Catholic Parish: _____

Other Denomination/Church: _____

Race: _____ How did you hear about Our Lady of Mercy School? _____

If other, please explain: _____

PLEASE SELECT THE SCHOOL OPTION YOU ARE INTERESTED IN:

HALF DAY:

FULL DAY:

Schedule: Monday to Friday
8:05 to 12:00

Lunch Bunch: 12:00 to 1:00
\$3.00 per day, billed monthly

Schedule: Monday to Friday
8:05 to 2:45

Hot lunch available, prepaid
one month in advance

If child is enrolling in the full day program, does the child currently take a nap? yes no (check one)

FAMILY INFORMATION:

Father/Guardian's Name _____

Address (if different from child's) _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Mobile Carrier _____

Email address: _____

Employer: _____ Position: _____

Place of Birth: _____ Religion: _____

Mother/Guardian's Name _____

Address (if different from child's) _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Mobile Carrier _____

Email address: _____

Employer: _____ Position: _____

Place of Birth: _____ Religion: _____

Parents' Marital Status: Married Widowed Single Separated Divorced Remarried

Child lives with: Both parents Mother Only Father Only Other: _____ Siblings

If custody is shared, who does the child stay with most often: _____

Please explain the custody arrangement (every other week, split week, summer and holidays, etc.): _____

SIBLING INFORMATION:

Name: _____ Age: _____ Grade: _____ School: _____
 Name: _____ Age: _____ Grade: _____ School: _____
 Name: _____ Age: _____ Grade: _____ School: _____
 Name: _____ Age: _____ Grade: _____ School: _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes no (check one)

List any allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns _____

List any particular fears or unique behavior characteristics the child has _____

List any types of medication taken for health care needs _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child _____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____ Office Phone _____
 Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator _____ Date _____

OFFICE USE ONLY

<input type="checkbox"/> \$75 Application Fee (non-refundable)	Cash / Check # _____	Date Received: _____
<input type="checkbox"/> Baptismal Certificate (if applicable)	<input type="checkbox"/> Birth Certificate (Copy)	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> \$150 non-refundable Curriculum Fee	Cash / Check # _____	Date Received: _____
<input type="checkbox"/> \$100 non-refundable Acceptance Fee	Cash / Check # _____	Date Received: _____