



# 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

## 2018-2019

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 AUGUST 31st** 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:**

**AFTER SCHOOL CARE NEEDED:**

**Schedule:** Monday to Friday  
8:05 am to 12:00 pm  
**Lunch Bunch:** 12:00 to 1:00  
\$3.00 per day, billed monthly

**Schedule:** Monday to Friday  
8:05 am to 2:45 pm  
Hot lunch available, prepaid  
one month in advance

**Schedule:** Monday to Friday  
2:45 pm to 5:30 pm

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: _____