**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 2019-2020

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:**

**Schedule:** Monday to Friday
8:05 am to 12:00 pm

☐ **FULL DAY:**

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

☐ **AFTER SCHOOL CARE NEEDED:**

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

*Availability based on demand

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 |
|---|---|---|---|
| Name | Relationship | Address | Phone Number |
| 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**

☐ $75 Application Fee (non-refundable) Cash / Check # _____ Date Received: _____

☐ Baptismal Certificate (if applicable) ☐ Birth Certificate (Copy) ☐ Immunization Record

☐ $150 non-refundable Curriculum Fee Cash / Check # _____ Date Received: _____

☐ $100 non-refundable Acceptance Fee Cash / Check # _____ Date Received: _____