



Charleston High School
 Department of Family & Consumer Sciences
 Preschool Registration Form

Date_____

School Year:_____

Name_____

Birth date: _____

Present Address_____

Home phone:_____

Mother's Name_____

Father's Name_____

Employer_____

Employer_____

Phone number _____

Phone number _____

Cell phone # _____

Cell phone# _____

Email address:_____

Email address:_____

In case of emergency, who should be notified?

Name_____

Phone_____

Name_____

Phone_____

Name and birthdates of other children in the family

Specific health needs (allergies, illness, medication, etc.)

Family Physician_____

Phone_____

If you and the physician of choice as indicated above cannot be reached in an emergency and , if in the judgment of school authorities immediate medical and/or hospital attention is indicated, do you authorize responsible school authorities to send your child(properly accompanied) to an available hospital or physician? Yes_____ No_____

Is there any other information that you would like to share?_____

 (Signature of Parent or Guardian)