

# Regional School District No. 6

## 2019-2020 KINDERGARTEN REGISTRATION

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Place of Birth: \_\_\_\_\_ Male(M)or Female(F): \_\_\_\_\_

Address: \_\_\_\_\_

Mailing address *if different* than address listed above:

(Mr. and Mrs. / Mr. / Mrs. / Ms. ) \_\_\_\_\_

Child Resides with: \_\_\_\_\_ Father/Mother \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Other

Alternate mailing Name/Address: \_\_\_\_\_

(For non-custodial parent, guardian, or separated household)

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Names of Brothers/Sisters: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Please list those we may contact in case we are unable to reach you during the day.

Name of Contact	Relationship to Child	Phone Number(s)	Cell Number

Do you give the school nurse permission to contact your child's Pediatrician or the School Doctor in an emergency if you or your contacts cannot be reached? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child have any allergies or special needs we should be aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of previous school attended (if applicable): \_\_\_\_\_