

**CHILD APPLICATION (\$20 application fee due when turned in) Date:** \_\_\_\_\_

(Please Print Legibly)

**HOLY SPIRIT PRESCHOOL**

3930 Parish Ave.  
Fremont, CA 94536  
hspreschool@csdo.org

\_\_\_\_\_ Catholic \_\_\_\_ Non-Catholic \_\_\_\_  
Family Name (Last name) \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

\_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_  
Child's Name (Last) (First) (Middle)

\_\_\_\_\_ City State Zip  
Home Address

\_\_\_\_\_ Cell Phone  
Home Phone

\_\_\_\_\_ E-Mail Address

Has your child attended preschool / daycare previously? Y or N If so, list below (more than 1, list on back):

\_\_\_\_\_ Phone \_\_\_\_\_ How long?  
School/Daycare City

Other Siblings (Name & Date of birth) \_\_\_\_\_

Siblings at Holy Spirit Elementary (Currently or previously) \_\_\_\_ Y \_\_\_\_ N If yes, what grade? \_\_\_\_\_

Father \_\_\_\_\_

Last Name First Name Place of Birth Religion  
Y \_\_\_\_ N \_\_\_\_

Occupation Employer Business Phone U.S. Citizen

Mother \_\_\_\_\_

Last Name First Name Place of Birth Religion  
Y \_\_\_\_ N \_\_\_\_

Occupation Employer Business Phone U.S. Citizen

**Check all home conditions that apply:**

Traditional \_\_\_\_ Divorced \_\_\_\_ Father Deceased \_\_\_\_ Mother Deceased \_\_\_\_ Foster Home \_\_\_\_ Mixed Religion \_\_\_\_  
Father Separated \_\_\_\_ Father Remarried \_\_\_\_ Mother Separated \_\_\_\_ Mother Remarried \_\_\_\_

Child lives with: Both Parents \_\_\_\_ Grandparents \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Guardian \_\_\_\_ Other \_\_\_\_

Race (Optional) Asian \_\_\_\_ Black/African American \_\_\_\_ Hispanic \_\_\_\_ Native American/Alaskan \_\_\_\_  
Pacific Islander/Native Hawaiian \_\_\_\_ White / Caucasian \_\_\_\_ Other \_\_\_\_

Are you registered at your Parish: Yes \_\_\_\_ No \_\_\_\_  
Name of your parish Envelope #

**For which program are you applying for: (All programs are Monday – Friday)**

\_\_\_\_ Caterpillar prgm: 3 years old as of Sept. 1st

\_\_\_\_ Butterfly prgm: 4 years old as of Sept. 1st

Are you interested in our Summer Program? Yes No (If applying for 3's, your child must be fully potty trained.)

Do you intend to send your child to Holy Spirit Elementary? Y / N (No guarantees, separate enrollment)

Are you willing to volunteer a minimum of 5 hours per school year? Yes No

**HOLY SPIRIT PRESCHOOL**  
**PRE-ADMISSION HEALTH/DEVELOPMENT HISTORY - PARENT'S REPORT**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Indicate age your child: walked unassisted \_\_\_\_\_ spoke words \_\_\_\_\_ spoke in sentences \_\_\_\_\_

Reason for requesting Preschool placement \_\_\_\_\_

Would you be able to volunteer in the classroom (5 mandatory hours per school year)? \_\_\_\_\_

**Sleeping Habits**

- What time does your child get up in the morning? \_\_\_\_\_ Go to bed? \_\_\_\_\_

- Does your child nap in the afternoon? \_\_\_\_\_ Does your child have frequent

nightmares? \_\_\_\_\_

**Toilet Habits**

- Is your child fully potty trained? \_\_\_\_\_ Does your child wear Pull-Ups? \_\_\_\_\_

- What words does your child say for Urination \_\_\_\_\_ Bowel Movement \_\_\_\_\_

- Does your child have a history of Bladder infections \_\_\_\_\_ Diarrhea or Constipation \_\_\_\_\_

Does your child suck his/her thumb during the day or have other pacifying routines? \_\_\_\_\_

**Social Setting**

Tell us something special about your child. \_\_\_\_\_

Briefly describe your child's relationship with his/her brothers and sisters \_\_\_\_\_

Group play experience (if any) \_\_\_\_\_

Are there other adults living in the home besides the parents? \_\_\_\_\_

Does your child have problems in being separated from you? \_\_\_\_\_

If your child is adopted, does he/she know it? \_\_\_\_\_

What do you consider to be your child's strengths and weaknesses? \_\_\_\_\_

What skills and/or experience do you feel are important for your child to receive in preschool ? \_\_\_\_\_

What discipline techniques do you use at home with your child? \_\_\_\_\_

Does your child eat independently? \_\_\_\_\_

Do you feel that your son/daughter has any special problems/fears of adjustment to friends, to school or to family that should be brought to the attention of your physician or school personnel? Y / N

Comments: \_\_\_\_\_

**COMPLETE OTHER SIDE**

**Language**

What is your child's primary language spoken in the home? \_\_\_\_\_

Does your child speak more than one (1) language fluently? Y / N.  
If yes, what language(s)? \_\_\_\_\_

**Medical History to be completed by Parent**

**Health History** (check the conditions where appropriate)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Allergy to Medications                     | <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Freq. Leg or Joint Pain | <input type="checkbox"/> Rubella (3 day measles)       |
| <input type="checkbox"/> Appendectomy                               | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Scarlet Fever                 |
| <input type="checkbox"/> Cerebral Palsy                             | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Chicken Pox                                | <input type="checkbox"/> Hernia (Rupture)        | <input type="checkbox"/> Sinus Trouble                 |
| <input type="checkbox"/> Concussion                                 | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Speech Difficulty             |
| <input type="checkbox"/> Defective Vision                           | <input type="checkbox"/> Lameness                | <input type="checkbox"/> Teeth Problems                |
| <input type="checkbox"/> Wears Glasses                              | <input type="checkbox"/> Measles (Rubeola)       | <input type="checkbox"/> Tires Easily                  |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Tonsillectomy                 |
| <input type="checkbox"/> Dizziness/blackouts                        | <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Ear Trouble                                | <input type="checkbox"/> Persistent Cough        | <input type="checkbox"/> Whooping Cough                |
| <input type="checkbox"/> Hearing Loss                               | <input type="checkbox"/> Poliomyelitis           | <input type="checkbox"/> Epilepsy                      |
| <input type="checkbox"/> Epilepsy                                   | <input type="checkbox"/> Recurrent Boils         | <input type="checkbox"/> Allergy to Foods (List Below) |
| <input type="checkbox"/> *Other (Please explain in the space below) |  |  |

\*Other medical conditions not listed above (birth defects/marks, ear/eye conditions, etc): \_\_\_\_\_

Does child have frequent colds? Y / N      Approximately how many in last year? \_\_\_\_\_

List any other serious illness, operation or injury and the age when this happened.

List all foods/substances/medications your child is allergic to (be specific): \_\_\_\_\_

Has your son or daughter had contact with and / or had tuberculosis? Y / N      Last contact \_\_\_\_\_

Has your child ever been advised not to participate in physical activity? Y / N

Is your child now under care for any medical problem? Y / N      If so, please specify \_\_\_\_\_

Does your child take any medication/vitamin/supplement on an ongoing daily basis? Y / N      If yes, please explain

What is the plan for your child when he/she becomes ill at school and who should we contact first?

Parent's Signature: \_\_\_\_\_      Date: \_\_\_\_\_