

IN PARTNERSHIP WITH:



Dear Parents,

Saint Gregory Parish School is proud to offer the 3-step-approach in early childhood learning.

The programs, Preschool (3 yr. old); Pre-K (4 yr. old) and Kindergarten (5 yr. old), are designed to be successive steps in promoting emotional, social and academic development.

Each level strives to meet the individual needs of the learner. Families are encouraged to follow the model, or choose the program which best fits your child's needs.

Saint Gregory Parish School ~  
"Where Faith and Knowledge Meet"  
COME – SEE THE DIFFERENCE!

\*Students and parents are encouraged to "shadow" the next classroom in the continuum of the early childhood programs at SGS.

**SCHEDULE A SHADOW DAY TODAY**

**814-725-4571**

 Then let them  
take it one  
step at a time.

 kindergarten



 Pre-K



 preschool



 At SGPS!!!

## St. Gregory Preschool

The preschool program is designed as an introduction into the classroom environment with an emphasis on learning about the community. The targeted age group is children who are

**3 years old by September 1st.**

## **Pre-Kindergarten**

The prekindergarten classroom focuses on kindergarten readiness skills. This program is designed for students who will enter Kindergarten the following school year or for students whose parents want them to have an extra year of preparation before starting Kindergarten. The program is for children who are

**4 years old by September 1st**

## **Kindergarten**

Full day kindergarten focuses on a balanced literacy approach exceeding kindergarten standards.

An individualized learning experience is available to children who are **5 years old by September 1st.**

*St. Gregory Parish  
School*

*In Partnership with  
Mercyhurst University*

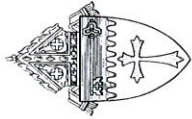
*Providing instructional  
support and the "Mercy  
Scholarship" which is a 75%  
reduction in college tuition to  
Mercyhurst University.*

**Tuition Assistance is available.**

Contact Nancy Pierce at the school for more information or with any questions.

**814-725-4571**

**The 3 distinct early  
childhood programs at  
Saint Gregory School are  
designed to be a  
continuum of learning—  
each striving to meet the  
individual needs of the  
learner.**



# Diocese of Erie Preschool Application Form

Please **PRINT** all information.

<b>PRESCHOOL</b>
THREE YEAR OLD _____
FOUR YEAR OLD _____
OTHER _____

## CHILD INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Grade Child Would Be Entering \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birth Certificate No. \_\_\_\_\_ Place of Birth \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ Religion \_\_\_\_\_

Address \_\_\_\_\_ HOUSE NO. \_\_\_\_\_ STREET \_\_\_\_\_ APT. NO. \_\_\_\_\_ LOT NO. \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ Phone \_\_\_\_\_

Child lives with: (Please Check) Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_ Legal Custody with \_\_\_\_\_ (Must have Court Papers)

Baptism \_\_\_\_\_ DATE \_\_\_\_\_ CHURCH \_\_\_\_\_ LOCATION \_\_\_\_\_ CERTIFICATE VERIFIED \_\_\_\_\_

Public School District of Residence \_\_\_\_\_ Did child attend another Preschool? No \_\_\_\_\_ Yes \_\_\_\_\_ If Yes, Name of School \_\_\_\_\_

What language(s) does the child speak? \_\_\_\_\_ What language(s) is spoken in the home? \_\_\_\_\_

## FAMILY INFORMATION

FIRST/LAST NAME	HOME ADDRESS	EMPLOYER'S NAME	WORK ADDRESS	WORK PHONE	HOME PHONE	CONTRIBUTING PARISHIONER OF:
FATHER						
MOTHER						
STEP-PARENT						
STEP-PARENT						
OTHER						

Other Children Living in Home

FIRST/LAST NAME	RELATIONSHIP TO APPLICANT	BIRTHDATE

Child's Physical Description at Time of Application.

EYE COLOR	HAIR COLOR
HEIGHT	WEIGHT

**HEALTH INFORMATION**

Original immunizations records are required. The school will make copies to insert in the application.

Does child have health insurance coverage? No  Yes

Name of Physician or Clinic: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Has child ever had surgery? No  Yes

Type of Operation: \_\_\_\_\_ Date: \_\_\_\_\_

Does child have allergies? No  Yes  Type: \_\_\_\_\_

Allergy Medication: \_\_\_\_\_

Does child have allergies to any medication? No  Yes  Type \_\_\_\_\_

List prescription medications child is currently taking: \_\_\_\_\_

Medical Conditions:

Diabetes: No  Yes  Heart Problems: No  Yes

Epilepsy: No  Yes  Asthma: No  Yes

Other: \_\_\_\_\_

**OTHER INFORMATION**

In order to properly plan for an incoming student, the school needs to know if there is any educational, developmental, psychological, behavioral, social, or medical history that affects the

Please check No or Yes. If Yes, please briefly describe.

Early Intervention Program: No  Yes

Developmental History: No  Yes

Medical History: No  Yes

Physical Conditions: No  Yes

Other: No  Yes

By placing my signature below, I (we) verify that all information is accurate and complete. I (we) realize that failure to provide accurate information about my (our) child may jeopardize enrollment at this school. I (we) further verify that no information has been omitted.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

Records were copied on: \_\_\_\_\_ DATE  
Initials: \_\_\_\_\_

# CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		WORK PHONE:
FACILITY PHONE:	COUNTY:	
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

**DO NOT OMIT ANY INFORMATION**  
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):  
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.  
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):  
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.  
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?  
 YES  NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT <a href="http://www.aap.org">WWW.AAP.ORG</a> ) <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.</b>
	VISION (subjective until age 3)
	HEARING (subjective until age 4)
	LEAD

**RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD**

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER:                      DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.