Date Registration Paid: _____

# HALIFAX ACADEMY PRE-KINDERGARTEN
## 1400 Three Bridges Road
## Roanoke Rapids, NC 27870

Date of Application: _____ For the _____ academic year

Admission is based on the following criteria:

1. Attitude of parents
2. Character and behavior of child
3. Age of child
4. Enrollment in class

Student's Name: _____
First Middle Last Preferred

Date of Birth: _____ Sex: _____ Age as of Oct. 31st _____
**Must be 4 by Oct 31st

Child's fears or unique behaviors: _____

**FATHER'S INFORMATION**

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Employer: _____

Occupation: _____

Phone: _____ Cell: _____

Work Phone: _____

Email: _____

**MOTHER'S INFORMATION**

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Employer: _____

Occupation: _____

Phone: _____ Cell: _____

Work Phone: _____

Email: _____

Child lives with: ☐Mother and Father ☐Mother ☐Father

References: (Two required – one preferred to be a member or employee of Halifax Academy)

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

Are YOU a member of Halifax Academy? ☐ YES ☐NO

## HALIFAX ACADEMY PRE-KINDERGARTEN

# EMERGENCY CONTACT INFORMATION

1. Name: _____ Telephone: _____

   Address: _____

   Relationship to Student: _____

2. Name: _____ Telephone: _____

   Address: _____

   Relationship to Student: _____

3. Name: _____ Telephone: _____

   Address: _____

   Relationship to Student: _____

**CHILD'S DOCTOR**: _____ Telephone: _____

Address: _____

**CHILD'S DENTIST**: _____ Telephone: _____

Address: _____

**HOSPITAL PREFERENCE**: _____

I agree that the operator/director may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Parent Signature: _____ Date: _____

I, as Operator/Director, do agree to provide transportation to an appropriate medical resource in the event of an 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. Provisions will be made for adequate and appropriate rest and outdoor play.

Operator/Director's Signature: _____ Date: _____

# CHILD'S MEDICAL REPORT

Child's Name: _____ DOB: _____
Name of Parent/Guardian: _____
Parent/Guardian Address: _____

**MEDICAL HISTORY** ( May be completed by parent)

1. Allergies: _____

2. Is your child currently under a doctor's care? _____ YES _____ NO
   If YES, for what reason: _____

3. Is your child on any continuous medication? _____ YES _____ NO
   If YES, what medication(s)? _____

4. Any previous hospitalizations or operations? _____ YES _____ NO
   If YES, when and for what? _____
   _____

5. Any history of significant diseases or recurrent illness? _____ YES _____ NO
   Diabetes? _____ Convulsions? _____ Heart Trouble? _____
   Other: _____
   When? _____

6. Does your child have any physical disabilities? _____ YES _____ NO
   If YES, please describe: _____

7. Does your child have any mental disabilities? _____ YES _____ NO
   If YES, please describe: _____

**PARENT/GUARDIAN SIGNATURE**: _____

**PHYSICIAN TO COMPLETE THIS PART:**

Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners ( or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for the EPSDT program.

Height: _____% Weight: _____%

Head: _____ Eyes: _____ Ears: _____ Nose: _____ Teeth: _____

Throat: _____ Neck: _____ Heart: _____ Chest: _____ Abd/Gu: _____

Ext.: _____ Neurological System: _____ Skin: _____

Results of Tuberculin Test, if given: Type: _____ Date: _____ Normal: _____ Abnormal: _____
Should activities be limited? _____ YES _____ NO If yes, explain _____
Any other recommendations? _____

Signature of authorized examiner/Title: _____

Office Address: _____

Date of Examination: _____ Phone #: _____

***** A COPY OF CHILD'S UPDATED IMMUNIZATION RECORDS IS REQUIRED *****