



342 Dorseyville Rd. ♦ Pittsburgh, PA 15215
412-963-8885

DATE: _____

REGISTRATION FORM

\$40.00 registration fee (non-refundable) must be returned with your completed Registration Form

Name of the Parish/Church I am registered in: _____

(Please check one) I am applying to have my child registered in the following class:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Little Dippers (Mon./Wed. 9am-10:30am) | Child must be 2 years old by Sept. 1 |
| <input type="checkbox"/> Little Dippers (Mon./Wed. 11am-12:30pm) | Child must be 2 years old by Sept. 1 |
| <input type="checkbox"/> Blue Big Dippers (Tues./Wed./Thurs. 9:15am-11:45am) | Child must be 3 years old by Sept. 1 |
| <input type="checkbox"/> Red Big Dippers (Tues./Thurs. 9:00am – 12:45pm) | Child must be 3 years old by Sept. 1 |
| <input type="checkbox"/> Shooting Stars (Mon./Tues./Wed./Thurs. 9am-11:30am) | Child must be 4 years old by Sept. 1 |

1. CHILD Male Female

First Name _____ Middle _____ Last _____

Child's Birth Date _____ Name you would like your child called _____

Name you would like your child to learn to **copy & trace** _____
(This name is used for cubbies, sign in, name tags, school work, etc.)

2. MOTHER

First Name _____ Middle _____ Last _____

Address _____ Home Phone _____

_____ Zip Code _____

E-mail _____ Cell Phone _____

Occupation _____ Work Hours _____

Where Employed _____ Work Phone _____

3. FATHER

First _____ Middle _____ Last _____

Address/Home Phone (if different from above) _____

E-mail _____ (if you wish to have Weekly Updates sent to you as well)

Occupation _____ Cell Phone _____

Where Employed _____ Work Phone _____

*2-day (Tues./Thurs.) session for Big Dippers would have the same number of hours as the 3-day session.
(Please complete other side)

4. AUTHORIZED ADULTS

For your child's safety, please list below the adults authorized to provide transportation for your child:

Name _____ Phone _____

Name _____ Phone _____

5. EMERGENCY INFORMATION

Name of person authorized to act for parent/guardian in an emergency (if parent/guardian is unavailable):

Name _____ Home Phone _____

Address _____ Cell Phone _____

Where Employed _____ Work Hours _____

Work Phone _____

Name of Physician _____ Office Phone _____

Address _____

Name of Dentist _____ Office Phone _____

Address _____

6. BACKGROUND INFORMATION

Allergies (foods, medicines, animals, etc.) _____

Medical Conditions/Educational Needs (chronic illnesses, premature birth, wears glasses, asthma, etc.) _____

Has your child received early intervention services (Alliance or DART)? If so, do they have a current IEP?

Other children in the family:

NAME	BIRTHDATE	SCHOOL

7. I DO HEREBY AUTHORIZE EMERGENCY MEDICAL CARE FOR MY CHILD.

