The Neighborhood Center
Business Address: 344 N. 7th St. Allentown, PA 18102
Mailing Address 3440 Lehigh St. P. O. Box 412 Allentown, PA 18103
kberard@theneighborhood-center.org

Child's Name _____
AM Pre-K – 9:00 – 11:30 _____

PM Pre-K – 12:30 – 3:00 _____

Pre-K Starts Monday, September 14, 2020

Your child must be 4 by September 1st

Pre-K Student Registration Checklist

- Student Registration Form, – Emergency Information, Computer use, Permission to go on a field trip, to take and post pictures
- The Neighborhood Center Rules – Must be signed and reviewed with your child
- Notice of Physical Examination
    - Please Check both sides on all applications

What Your Child must have to attend Pre-k, your child will not be accept if he/she does not have the following

- Proof of Birth Certification
- Proof of Physical
- Proof of Immunizations
- Must live in Allentown – (Allentown School District Area)
- An Application Fee $30.00

THE NEIGHBORHOOD CENTER Allentown

Pre-K Permission and Registration Form School Year 2020-21

9:00 – 11:30 AM _____ Today's Date _____

12:30 – 3:00 PM _____ Application Fee _____

Pre-K Starts Monday, September 14, 2019 Must be 4 by September 1st

Child's Last Name on Birth Certificate	Child's First Name	Child's Middle Name

Child's Date of Birth (Month, Day, and Year)	Child's Gender _____Male _____Female

Residence Information (Informacion de reidencia)

Street Address	Apt#	
City	State	Zip Code
Cell Phone	Cell Phone	

Parent information

Mother's /Guardian Full Name

Marital status

_____Single _____ Married _____ Separated _____ Divorced _____ Widowed
Employer Name
Employer Address
E-mail Address

If foster Parent, Name of agency placing the child: _____

Father's /Guardian Full Name

Marital status _____single _____ Married _____ Separated _____ Divorced _____ Widowed
Employer Name
Employer Address
E-mail Address

If foster Parent, Name of agency placing the child: _____

Picking child up from Pre-K

Who will be picking up your child from Pre-K

Name	Cell Phone	Relationship

Person (s) with whom the child resides – Others in the household – Adults and Children

Last Name, First, Middle	Birth date	Sex	Grade (if sibling)

Place of birth (Lugar de Nacimiento)

City	State	County

If not born in the United States, date of entry into the United State _____

Mother's age at birth _____

Baby's weight at birth _____

Were there any unusual conditions or problem at birth? (check all that applies)

_____ Difficult/long labor _____ Instrument delivery _____ Blue Baby

_____ Incubator _____ Blood transfusion _____ Premature _____ Post mature

_____ Caesarian _____ Jaundice _____ Breech birth _____ Oxygen at birth

Comments:

_____

Approximate age your child was

Sitting without support _____ Saying single words _____ Crawling _____ Talking in phrases

_____ Walking by self _____ Toilet trained _____ (Must be Potty trained to come to Pre-K)

Comments:

_____

History of infancy and Early childhood (check the following behavior which applies to your child)

_____ Hyperactive _____ short attention span _____ extremely tired/sleepy

_____ temper tantrums _____ unusual fears _____ negative reaction to affection

_____ defiance of authority _____ stuttering _____ difficulty playing with peers

_____ speech is not clear _____ high fevers _____ frequent stumbling or falling

_____ difficulty holding pencil _____ fainting _____ difficulty using scissors

_____ unusual tics or twitches _____ Poor coordination _____ difficulty expressing needs

_____ difficulty dressing self _____ difficulty separating from parent

_____ bed wetting _____ bowel/bladder problems _____ difficulty understanding directions

Comments/Concerns:

_____

_____

Current Medical Conditions

Seizures _____

Health Conditions/Concerns

_____ Diabetes _____ Asthma _____ Heart _____ ADHD _____ other

Special medications prescribed _____ No _____ Yes

Hospitalizations

Was your child ever hospitalized? _____ No _____ Yes If so, list dates and reasons for hospitalizations

_____

Did your child ever receive a head or back injury _____ No _____ Yes Date _____

Was your child unconscious? _____ No _____ Yes How long? _____

Did you child have a concussion? _____ No _____ Yes

Physician _____ Name of hospital of choice _____

Current Behavior

Does your child still take naps? No _____ Yes _____

Does your child have the opportunity to play with other children? No ___Yes ___

Has your child developed a hand preference? _____ left _____ right _____ both

Describe your child's greatest strength?

_____

How does your child get along with other children in the home?

_____

Language (Cuestionario)

1. What is the Student's first language? _____
2. Does the student speak a language(s) other than English ____ No ____ Yes if yes, specify _____
3. What language (s) is spoken at home?

Ethnicity – Choose One _____ Note Hispanic or Latino _____ Hispanic or Latino
Race – (Choose All that apply) _____ Ameri. Indian or Alaskan _____ Asian _____White _____ Native Hawaiian/Pacific Islander _____Black of African American