



Mary Carrico Catholic School  
Preschool/Extended Care Registration  
9546 Hwy 144  
Philpot, KY 42366  
270-281-5526

**Check one:**

- 3 day preschool
- 3 day with wrap around
- 5 day preschool
- 5 day with wrap around

Date of Enrollment \_\_\_\_\_

Child's Full Name \_\_\_\_\_

Name Child goes by \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Home Address \_\_\_\_\_ Zip \_\_\_\_\_

Child's Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Parent Email address \_\_\_\_\_

Child's Parish/Church \_\_\_\_\_ Baptized:  yes  no

**— Parent or Guardian Information —**

Father's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Father's Address \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Address \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Phone # \_\_\_\_\_

Name of person(s) with whom the child lives if other than parent/guardian:

\_\_\_\_\_ Relationship \_\_\_\_\_

Brothers and Sisters (please indicate ages and if they live with the child):

\_\_\_\_\_

**— Pick up —**

Emergency Contacts and Persons authorized to pick up child

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Persons **Unauthorized** to pick up child or have contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**— Personal/Medical History —**

Has child had a previous group or pre-school experience? \_\_\_\_\_

If so, where and when? \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Does your child have any sensitivities? \_\_\_\_\_

Are there any medical problems of which we should be aware? Describe \_\_\_\_\_

\_\_\_\_\_

Special food or eating instructions? \_\_\_\_\_

\_\_\_\_\_

Any additional information such as discipline, child's communication, comforting and so on? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*For third party professional services (ie, if child receives speech or other therapy while at preschool, please fill out "Third Party Professional" Form.)*

**— Emergency Information —**

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

In the event of an emergency, MCCS Preschool has my permission to call emergency services to care for my child.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**A current immunization  
record is required BEFORE your  
child can attend the first day.**

