

# St. Peter Preschool Enrollment



- \_\_\_ Tu/TH Morning Class (7:50 AM-11:00 AM)  
(Must be 3 years old by 9/1/26)  
\$200.00 per month
- \_\_\_ M-F Morning Class (7:50 AM-11:00 AM)  
(Must be 4 years old by 9/1/26)  
\$275.00 per month
- \_\_\_ M-F All Day Class (7:50 AM-3:20 PM)  
(Must be 4 years old by 9/1/26)  
\$550.00 per month

Parents' First and Last Name \_\_\_\_\_

<u>Child's Name</u>	<u>Age</u>	<u>Birthdate</u>
_____	_____	_____

	<u>Price</u>	<u>Total</u>
Materials/Supplies/Snack	\$150	_____
Monthly fee (1 <sup>st</sup> month)	\$200 / \$275 / \$550	_____
<b>Total due</b>		<b><u>\$350 / \$425 / \$700</u></b>

- Payment for preschool is non-refundable

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For Office Use Only:

**Total due: \$350 / \$425 / \$700**

Paid at Registration \$ \_\_\_\_\_ Balance due: \$ \_\_\_\_\_

Payment received: Check # \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card \_\_\_\_\_

Date: \_\_\_\_\_

Forms Received: \_\_\_ Birth Certificate \_\_\_ Baptismal Certificate

\_\_\_ Physical Form \_\_\_ Immunization Form

# St. Peter Catholic Preschool

## Family Information (Please print clearly)

Family Last Name: \_\_\_\_\_ Home Address: \_\_\_\_\_

Public School District  
In Which You Reside: \_\_\_\_\_

Home Parish: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Cell #: \_\_\_\_\_ Mother's Cell #: \_\_\_\_\_

Religion: \_\_\_\_\_ Religion: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Virtus Trained: \_\_\_ Yes \_\_\_ No      Virtus Trained: \_\_\_ Yes \_\_\_ No

Primary Language Spoken in the Home: \_\_\_\_\_

Parents' Marital Status (Please Circle):

Married      Widowed      Separated      Divorced      Remarried

Student resides with:

Both parents      Mother      Father

Other (Please Describe):

I would like to be:      Head Room Parent \_\_\_\_\_

Room Parent Helper \_\_\_\_\_

If you, your spouse or any adult or youth living in your home is listed on the National Sex Offender Public Registry, you and/or the offender are required to contact the Principal or Pastor prior to the offender being on school property, participating in school events, or the first day of school.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Regarding your preschool student:

Name: \_\_\_\_\_ Gender: Male Female  
(First, Middle, and Last)

Preferred Name (for name tags, etc.): \_\_\_\_\_

Birthdate: \_\_\_\_\_ Religion: \_\_\_\_\_

Past Schools Attended: \_\_\_\_\_

Does your child have needs that require accommodations? ILP or IEP \_\_\_Yes \_\_\_No

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Ethnicity (Circle One): American Indian  
Asian/Pacific Islander  
Hispanic  
Black  
White

Siblings and Ages: \_\_\_\_\_

**IF A PARENT CANNOT BE REACHED IN AN EMERGENCY, WHOM SHOULD WE CONTACT?**

(We will try to contact the parents first)

**PRINT CLEARLY**

TRY 1<sup>st</sup>: Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Phone Numbers: CELL \_\_\_\_\_ HOME \_\_\_\_\_  
WORK \_\_\_\_\_

TRY 2<sup>nd</sup>: Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Phone Numbers: CELL \_\_\_\_\_ HOME \_\_\_\_\_  
WORK \_\_\_\_\_

TRY 3<sup>rd</sup>: Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Phone Numbers: CELL \_\_\_\_\_ HOME \_\_\_\_\_  
WORK \_\_\_\_\_

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Diocesan Student Ethnic Background Form

To maximize our ability to meet the individual needs of all students, the Diocese is collecting the primary ethnic background of each student. This information will be used only by the Diocese and your school.

What is the **PRIMARY** ethnic background of your child (**please select one**)?

- **Caucasian/White** (A person whose family originally came from any of the European countries.)
- **Hispanic/Mexican** (A person whose family originally came from Mexico.)
- **Hispanic/Other than Mexican** (A person whose family originally came from Central or South America. For example: Cuba, Puerto Rico, Haiti, Honduras, El Salvador, Nicaragua, Guatemala, Columbia, Venezuela, Brazil, or Argentina.)
- **Asian-American/Vietnamese** (A person whose family originally came from Vietnam.)
- **Asian-American/Other than Vietnamese or Middle-Eastern** (A person whose family originally came from Asia. For example: China, Japan, Korea, Cambodia, India, Malaysia, Pakistan, Afghanistan, Philippine Islands, or Thailand.)
- **Middle-Eastern** (A person whose family originally came from the Middle East, southwest Asia, or northern Africa. For example: Lebanon, Iraq, Iran, Israel, Saudi Arabia, Syria, Turkey, Egypt, Tunisia, Libya.)
- **Black/African-American** (A person whose parents were born in this country but whose family originally came from Africa.)
- **Black/Not African-American** (A person who parents were born in Africa, Jamaica, Bahamas, Bermuda, Haiti, Dominican Republic or Grenada.)
- **American Indian (Native American)/Alaska Native/ Native Hawaiian/Pacific Islander** (A person whose family has origins from the original tribes or peoples of North America, Alaska, Hawaii, or the Pacific Islands.)



## School Communication Form

Family Name \_\_\_\_\_

Student Name \_\_\_\_\_

Email Address #1: \_\_\_\_\_

Email Address #2: \_\_\_\_\_

## Flocknote Information

Phone Number #1 \_\_\_\_\_

Please check one:  Home  Cell

Phone Number #2 (if applicable) \_\_\_\_\_

Please check one:  Home  Cell



**St. Peter Catholic School**  
**11010 Southwest Blvd.**  
**Wichita, KS 67215**  
**Brenda Hickok, Principal**

**(316) 524-6585**  
**Fax (316) 524-1656**

**PHYSICAL EXAMINATION FORM**

**Statement of Consent:** In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to school and other appropriate health professionals.

\_\_\_\_\_  
**Parent/Guardian**

\_\_\_\_\_  
**Date**

**Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Male/Female:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Physician:** \_\_\_\_\_ **Dentist:** \_\_\_\_\_

**CHILD/ADOLESCENT HISTORY**

Any chronic illness or disabling problems with:

Rheumatic Fever\_\_\_\_ Convulsions\_\_\_\_ Diabetes\_\_\_\_ Earaches\_\_\_\_ Genitalia \_\_\_\_  
 Colds/sore throat\_\_\_\_ Headaches\_\_\_\_ Oral/dental\_\_\_\_ Heart/lung disease\_\_\_\_ Digestive \_\_\_\_  
 Allergies/asthma\_\_\_\_ Urinary/bowel\_\_\_\_ Back/spine/extremity problems\_\_\_\_ Other \_\_\_\_

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hgb or Hct: \_\_\_\_\_ Pulse: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Urinalysis: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_ Other: \_\_\_\_\_

<b>Code Each Item as Follows:</b>	<b>Code:</b>	<b>Description of Findings:</b>
0= No significant findings		
1= Significant findings		
General Appearance		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		

**Screening**

Speech: Type of screen \_\_\_\_\_ Results \_\_\_\_\_  
 Hearing: Type of screen \_\_\_\_\_ Results \_\_\_\_\_  
 Vision: Type of screen \_\_\_\_\_ Results \_\_\_\_\_

Significant Assessment Findings:

Anticipatory Guidance: (circle those discussed)

- 1. Safety/poison
- 2. Nutrition
- 3. Lifestyle
- 4. Development

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 Signature of Licensed Physician or Nurse approved to perform health assessments