



APPLICATION FOR PRESCHOOL

NECESSARY DOCUMENTATION:

- Copy of Child's Birth Certificate
- Copy of Child's Immunization Card
- Copy of Child's Health Insurance Card
- Completed DOH Yearly Health Examination Form
- Copy of Parent(s) I.D. Card (can be driver's license, passport, or other proof of name and address)
- Non-refundable application fee in the amount \$50 payable by check or money order made out to Bright Beginnings NYC LLC¹

STUDENT INFORMATION:

Full Name: _____
(Last) (First)

(Middle) (Nickname)

Sex: Female Male

Date of Birth _____

PROGRAM PREFERENCE:

- Full Time (M, T, W, Th, F, 8:30 am – 5:30 pm)
- Part Time (M, T, W, Th, F)
 - Morning session (8:30 am – 12:00 pm)
 - Afternoon session (1:30 pm – 5:30 pm)²

Desired Date of Enrollment: _____

Name of Sibling who attended Bright Beginnings NYC: _____

FAMILY INFORMATION:

Child Lives With: _____
(Name / Relation)

Address:

Home Phone Work Phone Mobile Phone

Mother's Name: _____

Address:

Home Phone Work Phone Mobile Phone

Occupation E-mail

Father's Name: _____

Address:

Home Phone Work Phone Mobile Phone

Occupation E-mail

Custody: Mother Father Both
 Other

(describe)

Siblings: _____
(Sex, age)

Language(s) spoken in home: _____

Total Members of Household: _____

Combined Annual Family Income: _____³

FAMILY COMPOSITION:

Name of person living in home	Language spoken	Sex (M or F)	Relationship	Occupation	Age

Race: (please check one)⁴

- Native American or Alaskan Native
- Asian
- Multiracial/Biracial
- African American/Black
- Hispanic or Latino Other
- Caucasian/White
- Native Hawaiian/Pacific Islander

NAME OF PERSONS AUTHORIZED TO PICK UP CHILD FROM PRESCHOOL:

Name of Person	Relationship	Telephone Number

*The person picking up the child will be required to present identification when arriving at school.

MEDICAL INFORMATION:

Medical Contact Information:

- **Name of Medical Care Facility/Hospital:** _____
 - Telephone: _____
 - Doctor(s) Name(s): _____
 - _____
 - _____
- Date of Last Check-up (must be within 30 days of enrollment date): _____

- **Child's Source of Dental Care:** _____
 - Telephone: _____
 - Dentist(s) Name(s): _____

 - Date of Last Check-up (must be within 30 days of enrollment date): _____

Immunizations

Please attach a copy of your child's immunization card and health insurance information to this application. Upon admission into the Bright Beginnings NYC program, you will be required to update (a) your child's immunization information regularly by bringing in the documentation filled out by your child's physician; and (b) your child's health insurance information.

Please check all that apply, giving approximate dates of occurrence.

- Ear Infections _____
- Asthma _____
- Convulsions _____
- Penicillin _____
- Allergies _____
- Food Allergies _____
- Rheumatic Fever _____
- Insect Stings _____
- Hay Fever _____
- Ivy Poisoning _____
- Chronic conditions _____
- Other _____
- Chicken Pox _____
- Mumps _____
- Whooping Cough _____
- Measles _____
- Tuberculosis _____
- Meningitis _____
- Poliomyelitis _____

Please list all surgery, accidents, illnesses, chronic or handicapping problems, etc.

Any behavior or special considerations: Yes No

If yes, please answer questions below:

- Has child been evaluated? Yes No

If “Yes,” please attach evaluation.

Does your child currently have a therapist? Yes No

- If yes, what type? _____
- How many hours/week does he/she attend ? _____

EMERGENCY CONTACT:

Please list in order of preference:

Name	Relationship	Telephone

BACKGROUND INFORMATION:

Please list day care/preschool that your child previously attended and the reason for leaving:

Preschool Name	Dates Attended	Reason for leaving

Consent Form:

1. I, _____, as the _____ (parent or legal guardian) of _____ (the “Child”), consent to the enrollment of the Child in the pre-school program operated by Bright Beginnings NYC at 80 Beekman Street, New York, New York.
2. I have been advised of the policies followed by Bright Beginnings NYC regarding the administration of medications, fees and the services provided by the facility.
3. I give consent for my child to take part in neighborhood trips (i.e. library, park, and playground) away from the facility under the supervision of the staff employed by Bright Beginnings NYC.
4. In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital necessary for the proper health and well-being of the Child.
5. I have provided information on my child’s special needs (Allergies, Diet, Disabilities, and/or Medical Information) to Bright Beginnings NYC, as may be necessary to assist Bright Beginnings NYC in properly caring for my Child in case of an emergency.
6. I agree to review and update this information whenever a change occurs and at least once every six months.

SIGNATURE-PARENT OR PERSON LEGALLY RESPONSIBLE

Date:

FOR PROGRAM USE:

Application Given Out By: _____
Signed

Date:

¹ The application fee is waived for residents of South Bridge Towers upon proof of residency for the child and his/her parent(s) or legal guardian.

² Please note that we are currently in the process of amending our Certificate of Occupancy to enable us to use not only our classroom space on the first floor, but also the even larger space located downstairs as an indoor play area and additional classroom. Until we obtain a permit to use the downstairs area, we will only be able to offer a morning session half-day program, based on availability.

³ Bright Beginnings NYC reviews all applications for admission without regard to the applicant’s income.

⁴ Bright Beginnings NYC reviews all applications for admission without regard to the applicant’s race or ethnicity.