CHILD INFORMATION

Name: ______________________________ Address: ______________________________

Nickname: ______________________________ ______________________________

Age: __________ Date of Birth: ______________ ______________________________

☐ Male ☐ Female ______________________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name: ____
First *Last*

Home Phone: (______)______________________ Cell phone: (______) ______________________

Place of employment: ______________________Work phone: (______) ______________________

Parent/Guardian #2 Name: ____
First *Last*

Home Phone: (______)______________________ Cell phone: (______) ______________________

Place of employment: ______________________Work phone: (______) ______________________

Child lives with:
☐ Both parents ☐ Mom ☐ Dad ☐ Guardian &/or step parent

EMERGENCY CONTACTS

The following may be contacted if parent/guardian is unavailable and may pick-up my child in case of emergency:

Contact #1 Name: ____

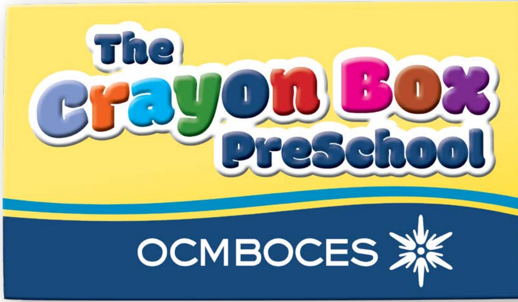
Phone: (______)______________________Relationship to child: ______________________

Contact #2 Name: ____

Phone: (______)______________________Relationship to child: ______________________

Contact #3 Name: ____

Phone: (______)______________________Relationship to child: ______________________



Phone: (315) 431-8403
Email: makershner@ocmboces.org
Online: ocmboces.org/crayonbox
Address: Thompson Road Campus
6820 Thompson Rd.
Syracuse, NY 13211
Forms: Photo permission form

SESSION

Please select the session you are applying for: ☐ a.m. ☐ p.m.

HEALTH HISTORY

Please complete and describe any health concerns this student has:

Allergies	☐ No	☐ Yes	Describe: ________________
Asthma	☐ No	☐ Yes	
Inhaler	☐ No	☐ Yes	
Broken Bones	☐ No	☐ Yes	Describe ________________
Diabetes	☐ No	☐ Yes	Describe: ________________
Epilepsy	☐ No	☐ Yes	Describe: ________________
Heart Condition	☐ No	☐ Yes	Describe: ________________
Known medical conditions	☐ No	☐ Yes	Diagnoses: ________________
Hospitalizations	☐ No	☐ Yes	If yes, for what? ________________
Daily medications	☐ No	☐ Yes	List: ________________

Pediatrician's Name: ________________ Phone: (________) ________________

*In order for your child to attend the Crayon Box Preschool, New York State requires that the following documents from your child's doctor/health care provider be attached to this form:

- Current Physical (within 12 months of the start of school)
- Immunization records

Parent/Guardian Signature: ________________ Date:_____/_____/ __________