



COX PRESCHOOL

630 South Main Street

Hightstown, NJ 08520

☎ (609) 443-4473

Student Information Form

Child's Name: _____ Birthdate: _____ Male Female

Mom's Name: _____ Dad's Name: _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Address: _____

Email Address: _____

Father's Occupation and Work Number: _____

Mother's Occupation and Work Number: _____

Child's Physician: _____ Physician Phone: _____

Emergency Contact and Phone: _____

Other Family Members: _____ Age: _____

_____ Age: _____

Any particular family situation: _____

Language spoken at home: _____ Religious Affiliation: _____

Has child had other group experiences? _____

Has child known allergies (food, medication)? _____

Has child known handicaps? _____

Has child known fears? _____

Has child daytime control of urination? _____

Are you interested in substituting? _____

Does parent have child-education background? _____

Has the school permission to take your child to the nearest hospital in case of emergency and there is no response at any of the above numbers? Yes No

We, the parents of the above child, hereby give our permission for his/her participation in the activities of Cox Preschool. These activities will include on/off the premises functions. Your child is covered by the school's insurance.

Parent Signature: _____ Date: _____