

**Good Shepherd Day School**  
544 Sayre Avenue, Lexington, KY 40508  
s: (859) 255-9734 • f: (859) 977-3844

**Child Enrollment Information**

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

\_\_\_\_\_  
Preferred Name at School

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Gender

\_\_\_\_\_  
Ethnicity

\_\_\_\_\_  
\*If child was born 3 or more weeks premature, please write  
how many weeks he/she was premature: \_\_\_\_\_

**Siblings (Names & Ages)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Group or School Experience** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Services**

Does your child receive any additional services (example-speech therapy, occupational therapy, etc.)? If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

**Parent/Guardian Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone (if applicable)

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Occupation

**Parent/Guardian Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone (if applicable)

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Occupation

**(OVER)**

**Emergency Contacts Other Than Parents** (Parents will always be contacted first.)

_____	_____	_____	_____
Name	Relationship to Child	Best Phone Number	OK to pick up?
_____	_____	_____	_____
Name	Relationship to Child	Best Phone Number	OK to pick up?
_____	_____	_____	_____
Name	Relationship to Child	Best Phone Number	OK to pick up?

**No Pick Up! Please give detailed information regarding any person NOT to pick up your child.**

\_\_\_\_\_

Name(s) Relationship(s) to Child

\_\_\_\_\_

Brief description:

\_\_\_\_\_

**Medical Information**

*\* If your child requires medicine or an epi-pen at school, a separate medical form will need to be completed. Please ask child's teacher for this form.*

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Daily Medications: \_\_\_\_\_ Hospital of Choice: \_\_\_\_\_

**Known Allergies**

*\* If your child requires medicine or an epi-pen at school, a separate medical form will need to be completed. Please ask child's teacher for this form.*

_____	_____	_____
Description	Severity (mild, moderate, severe)	Treatment
_____	_____	_____
Description	Severity (mild, moderate, severe)	Treatment

**Additional Information**

Please feel free to share any additional information about your child. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Permission to Give and/or Seek Emergency Treatment**

I give the staff and teachers of Good Shepherd Day School permission to give or seek emergency treatment for my child in the event treatment is needed and I cannot be reached.

\_\_\_\_\_

Signature of Parent(s)/Guardian(s) Date