Peru Catholic SCHOOL

FAITH • LOVE COMMUNITY

3 Year Old Preschool Sessions

3 Day Program

Tues., Wed. & Thurs.

5 Day Program

Monday-Friday

4 Year Old Preschool Sessions

3 Day Program

Tues., Wed. & Thurs.

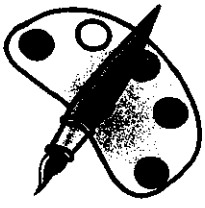
5 Day Program

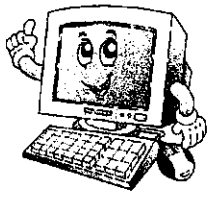
Monday-Friday

WHAT OUR PROGRAM INCLUDES:

- Reading
- Writing
- Math
- Science
- Religion
- Computers
- Music
- Art
- Library
- Physical Education

- Letter Recognition
- Proper Letter Formation
- Number Recognition
- Proper Number Formation
- Rhyming
- Sorting
- Patterns
- Estimating
- Grouping





- Creative Thinking
- Problem Solving
- Language Development
- Social Development
- Emotional Development
- Perceptual Development Skills

CALL FOR AN APPOINTMENT TO MEET THE TEACHER AND VISIT OUR PRESCHOOL CLASSES!

Please Check One

_____3 Yr. Old Program

_____4 Yr. Old Program

Preschool Pre-registration Questionnaire

Name of Child (print clearly)_____Nickname _____

Date of birth_____Age on first day of school_____

Father's Name _____ Mother's Name_____

Contact Numbers_____E-Mail Address_____

Child lives with: (check all that apply) ___mother ___father ___step-mother ___step-father ___grandmother ___grandfather
___foster parent's ___ other (please specify) _____

Has your child attended school before: ___yes ___no (Please Circle: Preschool – Daycare – Head-Start)

Please Check One: 3 Year Old Program: ___3 full days ___5 full days

4 Year Old Program: ___3 full days ___5 full days

Will you be continuing on at Peru Catholic School ___yes ___no, If no, where?_____
_____

IN ORDER TO ENROLL INTO THE PRESCHOOL PROGRAM AT PERU CATHOLIC, YOUR CHILD MUST BE FULLY POTTY TRAINED AND SELF-SUFFICIENT IN ALL ASPECTS OF PROPER HYGIENE.

Self-Care Survey: (check all that apply)

___My child is potty trained ___He/She can wipe their own BM ___He/She can wipe after urination ___He/She can pull up & pull down his/her own pants	___He/She is scared to go the bathroom alone ___He/She can dress them self (include: socks, shoes & coats) ___He/She can drink from a milk carton ___He/She nap

Check below any services that your child has received: ____speech and language therapy ____hearing services
____vision therapy ____occupational therapy ____physical therapy ____counseling

Is your child on any medication: ____yes ____no, If so, what? _____ How long?_____

Does your child have any allergies: ____yes ____no, If so please explain? _____
_____
_____

Parent's Signature:_____ Date:_____