



Milo Alphabets Kindergarten Registration 2019-2020

Date: _____

Student's Name:

Last Name	First Name	Middle Name(s)
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Birthdate: _____
DD/MM/YYYY

Father's Name: _____ Occupation: _____

Cell Number: _____ Email: _____

Mother's Name: _____ Occupation: _____

Cell Number: _____ Email: _____

Child Lives with: Mother _____ Father _____ Both _____ Other _____

If other please specify _____

Address: _____

Home Phone: _____ Daytime Phone: _____

Land Location (if a farm child): _____

Language Spoken at Home: _____

Number of Children in Family: _____

Names of siblings or other close family members at school:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alberta Health Care Number: _____

Family Doctor: _____

Name	Phone Number
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Emergency Contact: _____

Name	Phone Number
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Please check if your child has had any of the following:

Stomach Aches	
Convulsions	
Head Injury	
Unconsciousness	
Prolonged Fever	
Strep Throat	
Head Lice	
Asthma	

More than two Ear Infections	
Chicken Pox	
Allergies (specify)	

Other: _____

Does your child wear glasses? _____ Has your child had a hearing test? _____

Has your child had his/her vision tested by an optometrist? _____

Is your child able to speak most sounds correctly? _____

Does your child understand and respond when spoken to? _____

Are you aware of any speech problems or delays your child might have? _____

Can your child ride a tricycle? _____ Bicycle? _____

Can your child throw a ball? _____ Catch a ball? _____

Is your child able to manage buttons, snaps, and zippers? _____

Does your child use a tripod grip on a pencil? _____

Is your child: Left handed _____ Right handed _____ Both _____

Has your child attended pre-school? _____ If so, where? _____

Parent Signature: _____ **Date:** _____

