

Application Date: _____

For Office Use Only	
Status	
Reg.	Ext
Student ID	

**JONESBORO PUBLIC SCHOOLS
PRE-K APPLICATION**

Child's Name (Last)		(First)		(Middle)	
DOB	Gender	Race	SSN		
Fathers Name			Mothers Name		
Employer			Employer		
Work Phone	Cell Phone	Work Phone	Cell Phone		
Home Address					
City		State		Zip	
Home Phone					
Child lives with (Please Circle):	Father		Mother		Both
	Guardian	Step Parent	Foster Parent	Other: Please Specify	

Emergency Contact Information Person to call if parents cannot be reached	
Name	
Relationship	
Home/Cell Phone Numbers	
Address	
City/State	

List all adults (other than parents or emergency contact) who are authorized to take the child from the school.

Name/Relationship	Phone Number
Name/Relationship	Phone Number
Name/Relationship	Phone Number
Name/Relationship	Phone Number

Has your child ever been enrolled in another preschool or child care program?	Yes	No
If so, what is the name of that program:		
Names of Siblings		Age
Annual Income (Required because of ABC Funding)	\$	
Number of people in your family?		
How many people live in the home?		

Program Enrollment (Check all programs of interest)		
___ Arkansas Better Chance (ABC)-a no cost preschool program for families qualifying under state income level guidelines. (Must have a tax return for current year)		
___ ABC Extended Care	___	\$ 30 extended day (7a.m. - 5:30 p.m.)
___ Reduced pay	___	\$ 45 per week for regular day (7:45a.m. – 2:45p.m.)
	___	\$ 57.50 for extended day (7a.m. - 5:30 p.m.)
___ JPS employee	___	\$ 95 per week (7a.m.-5:30 p.m.)
___ Full pay	___	\$ 100 week for regular day (7:45 – 2:45)
	___	\$ 125 extended day (7a.m. - 5:30 p.m.)
___ Child Care Development Funding (voucher)	___	Amount determined by caseworker

Child's Physician:		Phone Number:	
Childs Dentist:		Phone Number:	
Child's Special Food Needs:			
Is your child currently participating in "special services" such as speech, occupational or physical therapy? Y N			
If Yes, with whom:			
___ Asthma		Any known allergies:	
Inhaler Used? Y N			
List any medications:			
___ Seizures	___ Diabetes	___ ADD/ADHD	Other:

Check any of the following with whom you had had contact concerning your child:

<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Family Doctor/Nurse	<input type="checkbox"/> Dentist
<input type="checkbox"/> Orthopedist	<input type="checkbox"/> Ear, Nose, Throat Specialist	<input type="checkbox"/> Ophthalmologist
<input type="checkbox"/> Psychiatrist/Psychologist	<input type="checkbox"/> Surgeon	<input type="checkbox"/> Speech Therapist
<input type="checkbox"/> Dietician/Nutritionist	<input type="checkbox"/> Audiologist	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Physical Therapist	
Others: (Please Specify)		

Parent Signature: _____ **Date:** _____

Additional information about your child:

Please bring copies of the following documents with this application:

- Birth Certificate
- Social Security Card
- Immunization (current)
- Physical (in the last 12 months)
- Proof of income
- Most recent tax return (if applying for ABC spot)

The Jonesboro Early Childhood Learning Center and Jonesboro Public Schools admits children and hires staff regardless of race, age, gender, disability, cultural heritage, marital status, political or religious belief.