East Buchanan C-1 School District
Parents as Teachers
Enrollment Record

100 Smith Street
Gower, MO 64454
(816) 424-6466 Ext. 129
Fax: (816) 424-3511

Date of Enrollment: ______________________________ Referred By: ___________________________________

Please provide the following information for the child(ren) you want to enroll in the program:

Child's Name: ______________________________________ Date of Birth: _______________________________
Gender (please circle): Male ☐ Female ☐ Race: _______________________________________

CHILD INFORMATION

Due Date: ____________________________________ Birth Weight: ______________________________

Any Illness or Complications during Delivery or Pregnancy: Yes ☐ No ☐

If yes, please describe: ____

Any hospitalization(s) since birth? Yes ☐ No ☐ If yes, list reason: _________________________________

Any current medical condition(s)? Yes ☐ No ☐ If yes, describe: ___________________________________

Healthcare Provider: ___________________________ Date of last physical exam:

Child's Name: ______________________________________ Date of Birth: _______________________________
Gender (please circle): Male ☐ Female ☐ Race: _______________________________________

CHILD INFORMATION

Due Date: ____________________________________ Birth Weight:______________________________

Any Illness or Complications during Delivery or Pregnancy: Yes ☐ No ☐

If yes, please describe:____

Any hospitalization(s) since birth? Yes ☐ No ☐ If yes, list reason:_________________________________

Any current medical condition(s)? Yes ☐ No ☐ If yes, describe: ___________________________________

Healthcare Provider: ___________________________ Date of last physical exam:

Child's Name: ______________________________________ Date of Birth: _______________________________
Gender (please circle): Male ☐ Female ☐ Race: _______________________________________

CHILD INFORMATION

Due Date: ____________________________________ Birth Weight: ______________________________

Any Illness or Complications during Delivery or Pregnancy: Yes ☐ No ☐

If yes, please describe: ____

Any hospitalization(s) since birth? Yes ☐ No ☐ If yes, list reason: _________________________________

Any current medical condition(s)? Yes ☐ No ☐ If yes, describe: ___________________________________

Healthcare Provider: ___________________________ Date of last physical exam:__________________________

Parent/Guardian Information	Mother	Father	Guardian
First Name			
Last Name			
Marital Status			
Last Grade Completed in School			
Language Most Often Used			
Currently Employed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Full-Time or Part-Time	☐ Full ☐ Part	☐ Full ☐ Part	☐ Full ☐ Part

Phone number(s): ____Best time to contact family: _________________________

Street Address: ____

City: ___________________________________ State: ____________________________ Zip Code: ________________________

Email Address: ____

Alternate contact name/phone number in case of Emergency: ____

What is your reason for joining the program? ____

Name of Sibling(s) Living in the Home	Gender	Age

Name of Resident(s) in Home other than Family	Gender	Relationship to Child

Please return the form to Parents as Teachers,

Attn: Hope Georges via mail, fax, or email to

Georges@ebs.k12.mo.us

FOR OFFICE USE ONLY: Date received: ____