



BILINGUAL • DAYCARE • PRE-SCHOOL
Petits Poussins Too
2235 Frederick Douglass Blvd.
New York, NY 10027

APPLICATION: ONE-TIME FAMILY FEE: \$ 200.00

Academic year: ____ / ____ **What would be your ideal start date?** _____

Program: Infant Toddler Preschool

Child's name: First _____ (Middle) _____ Last _____

Date of Birth: _____ Place of Birth: _____ Sex: ____ Age on Sept 1: ____ yr ____ months

Street Address: _____ City: _____ Zip Code: _____

<p>Guardian 1: <input type="checkbox"/> Mother <input type="checkbox"/> Father</p> <p>First & Last name: _____</p> <p>Cell number: (____) _____</p> <p>Email: _____</p> <p>Employer: _____</p> <p>Business: (____) _____</p>

<p>Guardian 2 : <input type="checkbox"/> Mother <input type="checkbox"/> Father</p> <p>First & Last name: _____</p> <p>Cell number:(____) _____</p> <p>Email: _____</p> <p>Employer: _____</p> <p>Business: (____) _____</p>

Home phone#: (____) _____

Does your child speak French? (Y) (N) Do parents speak French? (Y) (N)

If parents are not at same address, who should we address correspondence to?

→ **In case of Emergency name of relative or friend who can be called if we are unable to reach you:**

Name: _____ Telephone: (____) _____

Street Address: _____ City: _____ Zip Code: _____

Name of Doctor to be called in case of Emergency: _____

Telephone of Doctor: (____) _____



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SEPTEMBER- JUNE

- Full Day (Monday through Friday):** 8:00 am - 3:00 pm
- Three Days (Monday, Wednesday & Friday):** 8:00 am - 3:00 pm
- Two Days (Tuesday & Thursday):** 8:00 am - 3:00 pm
- Enrichment** 3:00 pm-6:00pm: Monday through Friday

Attention!! Mailing address is different from school address:

Mail it to: **Attn: Ms. Vanessa Handal-Ghenania**
Petits Poussins Too
311 West 127th Street, Suite 410
New York, NY 10027

Petits Poussins Too is not permitted to administer any medication, if needed, please do so at home or after school.

Do you authorize staff and Director of Petits Poussins Too Preschool to administer all necessary Emergency and First Aid care for your child? (Y) (N)

List any allergies your child has, or medical conditions, seizures, Asthma, handicap, he/she has:

Does your child have any disability? (Y) (N) If yes, please specify_____

Any speech delays? (Y) (N) If yes, please specify_____

New York Department of Health requires that all children are vaccinated for school entrance.
Do you vaccinate your child? (Y) (N)

I, hereby, authorize Petits Poussins Too Preschool to provide care for my child.

I declare to the best of my knowledge that all the statements made in this application are true.

First & Last name (Guardian 1):_____ First & Last name (Guardian 2):_____

Signature:_____ Signature:_____

Date:_____ Date:_____