



## Greenwich Nursery School

17 Greenwich Church Road  
Stewartsville, NJ 08886  
Phone 908-479-6886 • Fax 908-479-4269  
[www.greenwichnursery.com](http://www.greenwichnursery.com)

### ENROLLMENT FORM 2026-2027

1. Child's Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_
2. If there is a nickname or another name you want your child to use and learn in school, please write here: \_\_\_\_\_
  - a. (e.g. Robert goes by 'Robbie', but his parents want us to use 'Robert' on his name card or Violet Rose who goes by 'Rose' and her parents want us to use 'Rose' on her name card. We want to teach your child the name you want them to know.)
3. Parents: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Mother \_\_\_\_\_  
Father \_\_\_\_\_ Custody: \_\_\_\_\_
4. Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
5. School District Child Will Attend: \_\_\_\_\_
6. Siblings: (names, ages)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Other Members of Household: (name, relationship)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Pets: (names, types)  
\_\_\_\_\_  
\_\_\_\_\_

9. Does your child have any health problems that we should be aware of?  
\_\_\_\_\_

10. Does your child take medication regularly? \_\_\_\_\_  
\_\_\_\_\_

11. Please describe any allergies (food, medicine, bee stings, etc.) your child may have.  
\_\_\_\_\_  
\_\_\_\_\_

12. Is there any additional information you feel we should know concerning your child's health? \_\_\_\_\_

13. Does your child wear glasses? Circle one    YES    NO

14. My child is (circle one)      LEFT HANDED      RIGHT HANDED

15. How would you describe your child's speech? \_\_\_\_\_

16. Please describe any dislikes, fears, or phobias your child may have.  
\_\_\_\_\_  
\_\_\_\_\_

17. Please describe any unusual toilet habits your child may have.  
\_\_\_\_\_  
\_\_\_\_\_

18. Has your child attended preschool or daycare prior to GNS? If so, please describe previous experience.  
\_\_\_\_\_  
\_\_\_\_\_

19. Do you have any special hobbies or interests to share with children?  
\_\_\_\_\_  
\_\_\_\_\_

20. Do you have any concerns or questions about any aspect of your child's development?  
(physical, social, emotional, intellectual) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. What do you hope will be included in your child's preschool program?  
\_\_\_\_\_  
\_\_\_\_\_

22. How would you evaluate your child's personality? (circle traits that apply)

Happy	Aggressive	Friendly	Moody
Dependent	Stubborn	Impulsive	Fearful
Sleepy	Even-Tempered	Attentive	Sympathetic
Good-Natured	Shy	Quiet	Clumsy

23. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Is there anything else you feel that we should know about your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Date)