

**Griswold Community Schools  
Tiger Club Preschool Application 2025-2026**

Child's Legal Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  M  F

Mother's/Guardian's Name: \_\_\_\_\_   
Last First Student Residence

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_ other email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Father's/Guardian's Name: \_\_\_\_\_   
Last First Student Residence

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_ other email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

**Please rank in order of preference.**

- \_\_\_\_\_ Full Time
- \_\_\_\_\_ Half Time
- \_\_\_\_\_ No Preference

Based on applications and requests received by May 19, 2025 students will be assigned to a program.  
Families may apply after the above date if space is available.

An informational letter will be sent to your family to notify you of the assigned program.

If you have a concern about the development of your child or a physical concern, an individual screening  
may be scheduled. Please call Lisa Butler at: Griswold Elementary (712) 778-2154

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Office use only:

Registration date: \_\_\_\_\_

Age 5 Before September 15<sup>th</sup> \_\_\_\_\_

Medical Examination Signed \_\_\_\_\_

Assigned Program: \_\_\_\_\_

Immunizations: \_\_\_\_\_

Boost for Families Grant      Griswold Community School Tuition Grant       Level One       Level Two

**Please complete each section**

What is the primary language spoken in the home? English Other: \_\_\_\_\_

Total number of people living in your household (including other relatives) \_\_\_\_\_

Do any of the following apply to your child or family situation?

Academic Factors: Does your child have .....

An Individual Education Plan (IEP)	Yes	No
A Hearing Impairment	Yes	No
A Vision Impairment	Yes	No

**Biological Risk Factors**

Born under 3 pounds	Yes	No
Diagnosed with a medical condition (i.e. Down Syndrome, Autism, ADAD, etc)	Yes	No

Has been diagnosed with or is suspected to have any of the following that may require special education or related services. Please mark those that apply

Speech or Language Impairment	Yes	No
Emotional/Behavior Disorder	Yes	No
Health Impairment	Yes	No
Other: _____		

**Special Circumstances:**

Resides in a foster care home	Yes	No
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Other issues or concerns you may have about your child.