

Has your child been around children or adults with disabilities? Yes / No If yes, please explain _____

What would you like your child to gain from the preschool peer model experience?

Please indicate the days you would like your child to attend:

____ Tuesday and Thursday (3 & 4 year olds) ____ A.M. ____ P.M.

____ Monday, Wednesday, and Friday (4 & 5 year olds) ____ A.M. ____ P.M.

Any other comments (allergies, health concerns, etc.):

I confirm that the information provided on this application is complete and accurate. I have read the Peer Model Program Information on the enclosed sheet and agree to all conditions mentioned. I understand that transportation is not provided.

Parent Signature

Date

Please return completed application to:

Shelbyville Central Schools

Attn: Kathy West

803 St. Joseph Street

Shelbyville, IN 46176

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