

Stepping Stones Preschool

Enrollment Form - 2011-2012

Child's Name _____ Date of Birth _____

Child's Address _____ Home Phone _____

City, State _____ Zip Code _____

Date of Admission _____ Hours in Care 9:00 a.m. - 2:30 p.m.

Parent's Name _____ Address, if different _____

Phone # while child is in care: MOTHER-Business _____ Home _____ Cell _____

FATHER -Business _____ Home _____ Cell _____

Person to call in case of an EMERGENCY if *Stepping Stones* cannot reach parents and/or guardian:

Name _____ Relationship _____ Phone _____

I hereby authorize *Stepping Stones* to allow my child to leave the child care facility ONLY with the following persons:

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE NUMBER</u>	<u>TX DRIVERS LICENSE #</u>
1)	_____	<u>mother</u>	_____	_____
2)	_____	<u>father</u>	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

INFORMATION IN THIS SECTION IS VERY IMPORTANT AND SHOULD BE COMPLETELY FILLED OUT. THE STATE REVIEWS FILES FOR COMPLETE DATA ON EACH STUDENT ENROLLED IN THE PROGRAM. PLEASE PROVIDE ALL NUMBERS REQUESTED. THANK YOU.

List any special problems that your child may have, such as ALLERGIES, EXISTING ILLNESS, PREVIOUS SERIOUS ILLNESS, INJURIES during the past 12 months, any MEDICATIONS prescribed for long-term continuous use, and any other information which staff should be aware of:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician _____ Address _____ Phone # _____

Name of Hospital _____ Address _____ Phone # _____

I give my consent for necessary treatment when my child is in the care of this physician and/or hospital/clinic. I release *Stepping Stones Preschool* and its agents from any liability for any action taken.

SIGNATURE--Parent OR Legal Guardian

TRANSPORTATION: I hereby [] give [] not give my consent for my child to be transported and supervised by facility staff for **field trips**. Initials: _____

IMMUNIZATION: My child's immunization record is on file at *Stepping Stones Preschool* and all immunizations are current. Initials: _____

Updated January 14, 2007

(COMPLETE BOTH SIDES OF THIS FORM)

HEALTH REQUIREMENTS

Name of Child _____	Date of Birth _____
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IMMUNIZATIONS	DATE/DOSE 1	DATE/DOSE 2	DATE/DOSE 3	DATE/BOOSTER	DATE/BOOSTER
DPT/TD					
POLIO					
MEASLES: Vaccine-Rubella					
MUMPS: Vaccine					
RUBELLA: Vaccine					
H. I. B.					
CHICKEN POX (Varicella)					
Hepatitis A					
Hepatitis B					
T.B. TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:		

Date _____	Date _____
Signature of Staff Completing Chart Record	Signature of Physician or Health Personnel

ADMISSION REQUIREMENTS:

One of the following must be presented when your preschool age child is admitted to the child care facility OR within one week of admission. Check to indicate the option you select:

1) _____ CURRENT copy of an immunization record for each child enrolled in program from a health service or clinic.

NOTE: If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign and affidavit to that effect and attach it to this form. If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (SIGNED BY A PHYSICIAN) to that effect and attach it to this form.

2) _____ **PARENT'S SIGNED STATEMENT.** My child has been examined within the past year by a licensed physician and is able to participate in the child care program (complete blanks in following box):

Name & Address of Physician OR address of Clinic or Screening Site _____

NOTE: Within the next 12 months, I will obtain a physician's statement, or a form or statement from a health service or clinic and will submit it to **Stepping Stones Preschool.**

OR

3) _____ My child has an appointment for a physical examination (complete blanks in following box):

Date _____ Name & Address of Physician _____

OR address of Clinic Screening Site _____

NOTE: I will submit the physician's statement, EPSDT form, or health service or clinic form to the child care facility following the examination.

SIGNATURE of Parent or Legal Guardian

Date

(COMPLETE BOTH SIDES OF THIS FORM)