Hand in Hand
PRESCHOOL

CHILD ENROLLMENT FORM

Name of Child _____ Classroom: _____ Start Date _____

Name Used/Nickname for Child _____ Date of Birth _____ Sex: M_____ F_____

Street Address for Child _____

City _____ State _____ Zip _____ Home Phone _____

**Allergies/Dietary Restrictions:

_____

_____

Attendance Schedule – Please Circle Which Days M T W Th F Full Days _____ Half Days _____

Please Indicate Hours _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name _____ Home Phone _____

Street Address for Parent/Guardian _____

City _____ State _____ Zip _____ Occupation/Position _____

Name of Employer _____ Work Phone _____ Cell Phone _____

Parent/Guardian Name _____ Home Phone _____

Street Address for Parent/Guardian _____

City _____ State _____ Zip _____ Occupation/Position _____

Name of Employer _____ Work Phone _____ Cell Phone _____

Marital Status of Parents: Married _____ Single _____ Divorced _____ Separated _____

For Divorced Parents – Which Parents has Legal Custody _____

Visiting/Custody Arrangements & Restrictions:

_____

_____

(Please provide a copy of all legal documentation from the court to be kept on record.)

Who Does Child Live With: _____

Name and Ages of Siblings: _____

AUTHORIZED CONTACTS

Authorized individuals who child can be released to when the parent(s)/guardian(s) are unavailable.
(At time of pickup, photo identification is required for each authorized person.)

1)Name_____Relation to Child_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

2)Name_____Relation to Child_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

3)Name_____Relation to Child_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

PERMISSION TO RELEASE OF INFORMATION

I (Grant/Do Not Grant) permission for Hand in Hand to release information about my child to official authorities of a school, medical or emergency care provider, welfare or other governmental agency. I do understand that the Bureau of Services for Child Care has access to my child's records as the licensing agency and may review the record upon BSCC facility inspection.

Signature of Parent/Guardian _____

ENROLLMENT AGREEMENT

_____I agree to pay a $75 non-refundable registration fee at the time of enrollment and annually during the anniversary month of my child's enrollment.

_____I understand that in order for my child to remain enrolled that tuition must be paid in advance on Monday or on the first day of attendance every week.

_____I understand that a 10% late fee will be applied to all tuition payments that are received after 6:00 pm on Tuesday for the current week of attendance.

_____I agree to pay a $25.00 service charge for each check returned due to insufficient funds. Only cash, a cashier check, or a money order will be accepted as an alternate form of payment. Hand in Hand reserves the right to refuse personal checks for any future payments.

_____With the exception of emergencies or uncontrollable circumstances, I agree to pay a late–pick up fee of $1.00 for every minute past the 6:00 p.m. closing time that my child remains at the center.

_____I agree to provide a one-week advance notice in writing for the withdrawal of my child from the program. Otherwise, I understand that the contracted one-week tuition amount must be paid in full.

_____I have received the Parent Handbook so that I can become fully informed about the philosophy, program, policies, and procedures of Hand in Hand Preschool & Early Development Center.

_____I have read and understand the information contained in this enrollment agreement. I agree to abide by the terms and conditions as set forth above as well as the policies and procedures as specified in the Parent Handbook. I further agree to pay all attorney and collection fees incurred by Hand in Hand should I default in any of the terms and conditions of the preceding enrollment agreement.

Signature of Parent/Guardian_____Date_____

Signature of Parent/Guardian_____Date_____

EMERGENCY CARE AUTHORIZATION FORM

Name of Child _____ Birth Date _____

Name of Parent/Legal Guardian _____

Telephone Numbers: Home _____ Work _____ Cellular _____

Name of Parent/Legal Guardian _____

Telephone Numbers: Home _____ Work _____ Cellular _____

Emergency Contacts (Individuals child can be released to if parent/legal guardian is unavailable)

Name _____ Relationship _____

Telephone Numbers: Home _____ Work _____ Cellular _____

Name _____ Relationship _____

Telephone Numbers: Home _____ Work _____ Cellular _____

Child's Physician / Medical Clinic

Physician's Name _____ Clinic's Name _____

Address _____

Telephone Number (s) _____ Fax Number _____

Child's Medical Insurance Coverage

Primary Health Insurance _____ ID # _____

Secondary Health Insurance _____ ID # _____

Preferred Emergency Services

Name of Hospital _____ Ambulance Service _____

(Parents/Legal Guardians are responsible to all emergency expenses incurred)

Special Conditions, Allergies, Disabilities or Medical Information

_____

_____

_____

Parent/Legal Guardian Consent & Agreement for Emergencies

As parent/legal guardian, I give consent for my child to receive first aid by center employees and, if needed, to be transported to receive medical and/or emergency care. I understand that I will be responsible for any expenses related to the examination, diagnosis, treatment, and transportation of my child. I give consent and authorization to the individual(s) listed above under Emergency Contacts to act on my behalf until I am available. I agree to review and update the information on this form whenever a change occurs.

Date: _____ Parent/Legal Guardian Signature: _____

Date: _____ Parent/Legal Guardian Signature: _____

Hand in Hand
PRESCHOOL

MEDICAL OFFICE STAMP

Pre-Admission Statement of Health

(To Be Completed by Medical Provider Only)

Name of Child_____ Date of Birth_____ Date of Examination_____

Name of Physician or Medical Clinic_____

Address of Physician or Medical Clinic_____

1) Does this child require any special care of attention when participating in activities? NO____ YES____
Please describe_____
2) Does this child have any health problems or medical conditions that restrict the level of involvement in a child care/preschool program? NO____ YES____
3) Does this child have allergies or dietary restrictions? NO____ YES____
Please describe_____
4) Is this child required to take prescription medication and/or dietary supplements? NO____ YES____
Please specify_____

Additional remarks from Physician_____
_____

I certify that the above named child is free from any communicable or infectious disease as of the date of examination and is able to be enrolled in a child care/preschool facility. This child is current with immunizations that are required for his/her age as in accordance with the standard immunization schedule.

Signature of Physician_____ Date_____

The parents have been informed of the risks associated with the waiver of immunization, but have opted to not have their child vaccinated.

Signature of Physician_____ Date_____

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PRESCHOOL

Field Trip Permission Form

Child's Name _____ Date_____

Date of Birth_____ Parent's Name_____

I authorize Hand in Hand to allow my child to participate and take part in the many field trips and educational tours that occur throughout the year. The transportation for the field trips and educational tours is to be provided by the center in the facility van/bus or by parent volunteers in private cars. I understand that at all times my child will be supervised and transported only by a responsible adult while on any of the field trips or educational tours available in the program.

In the event that an accident or injury occurs while my child is away from the center on a field trip or educational tour, I shall not hold the center, the center's employees or any participating adult liable for any such accident or injury.

_____ _____

Signature of Parent/Legal Guardian Date

I have decided not to grant authorization for my child to participate in any of the field trips or educational excursions.

_____ _____

Signature of Parent/Legal Guardian Date

CHILD CARE REGISTRATION FORM

Name of Child Care Facility: _____

Child's Surname: _____ First Name: _____ Religion: _____ Sex: _____

Home Address: _____ Home Phone: _____ Birthdate: _____

Father's Name: _____ Home Address: _____ Home Phone: _____

Employer: _____ Business Address: _____ Business Phone: _____

Mother's Name: _____ Home Address: _____ Home Phone: _____

Employer: _____ Business Address: _____ Business Phone: _____

Authorized Escort (If other than parent) or persons who may be called in emergency:

Name: _____ Address: _____ Relation: _____ Phone: _____

Name: _____ Address: _____ Relation: _____ Phone: _____

REQUIRED SHOTS: (Must be viewed by Child Care Facility)

Recorded With: Doctor _____ Health Dept. _____ Military: _____

DATES	DTP	IPV	MMR	HIB	HEPB	HEPA	VZV	PCV7	ROTA	FLU	H1N1
	1.	1.	1.	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2	2.	2.	2.	2.	2.
	3.	3.		3.	3.			3.			
	4.	4.		4.				4.			
	5.										

DPT-(Diptheria-Pertusis-Tetanus) **MMR-(Measles-Mumps-Rubella)** **HIB-(Haemophilus Influenza Type B)** **PCV7-(Pneumococcal)** **IPV-(Polio)**
HBV-(Hepatitis B) **VZV-(Varicella/Chicken Pox)** **HAV-(Hepatitis A)** **ROTA-(Rotavirus)**

**Please indicate medical reason if your child cannot receive a required immunization _____

_____

In the event of accident or illness to the child, I hereby authorize operator of this child care facility to secure any necessary medical and/or treatment from: Doctor _____ or the doctor who is on call or available or from the _____ hospital/clinic or the nearest hospital or clinic.

In the event I cannot be contacted immediately for notification or shall fail or refuse to remove the child affected with a communicable disease or other valid reason after notification of illness and request for removal of the child: I understand that the appropriate authorities may remove my child from the premises of this child care facility.

Furthermore, I agree to be directly responsible for all costs and expenses connected with the examination, diagnosis, treatment and removal of this child.

Date: _____ Signature of Parent or Guardian _____

Health Record of Child

Date child had last physical exam: _____ Physician's Name: _____

Give date if child has had any of the following:

Chicken Pox: _____ Mumps: _____ Measles: _____

Asthma: _____ Hay Fever: _____ Epilepsy: _____

Diabetes: _____ Whooping Cough: _____ Rheumatic Fever: _____

Is the child allergic to any foods? _____ Does the child have any special problems? _____

Has child ever been in licensed child care before? _____

If so, where: _____

Date of Admission: _____ Date of Discharge _____