



10555 Spring Cypress Road, Houston, TX 77070

Phone: 281 378 4080 Fax: 281 378 4081

Enrollment Form 2019-2020

Building Bridges, Preschool 3's & 4's

Please complete entire form, do not leave blanks. PRINT CLEARLY!

Registration Fees are Non-Refundable for any reason.

Office Use Only

Reg. # _____ Date _____

Fees paid _____

Check# _____ Cash _____

Paperwork: HF HS SR

Child's Full Name Last: _____ First: _____ Middle: _____

Date of Birth _____ Child's Age on September 1, 2019: _____ Gender: M / F

Child's Home Address _____ City, State, Zip _____

Child's Home Phone Number _____ Date of Admission _____

Mother's Full Name _____

Mother's Home Phone Number _____

Mother's Work Phone Number _____

Mother's Cell Phone Number _____

Mother's Address _____

Mother's City, State, Zip _____

Mother's Email Address _____

Place of Employment _____

Father's Full Name _____

Father's Home Phone Number _____

Father's Work Phone Number _____

Father's Cell Phone Number _____

Father's Address _____

Father's City, State, Zip _____

Father's Email Address _____

Place of Employment _____

Is there a custody order on file with the State of Texas? (circle) YES NO PENDING

*If YES, a current copy of your court order must be attached

Attendance: My child will be in attendance.

___ Monday/Wednesday/Friday (9:00am-2:30pm)

___ Monday through Friday (9:00am-2:30pm)+++

___ Tuesday/Thursday (9:00am-1:00pm) For 3's only

___ Tuesday/Thursday (9:00am-2:30pm)

Before Care: (Circle Time) 7:15 am-8:00 am

8:00 am-9:00 am

Mon. ___ Tues. ___ Weds. ___ Thurs. ___ Fri. ___

Extended Care: (Circle Time) 2:30 pm-4:00pm

2:30pm-5:00pm

2:30pm-6:00pm

Mon. ___ Tues. ___ Weds. ___ Thurs. ___ Fri. ___

+++ M-F class may be taught by more than one set of teachers. Extended Care is not available for the class that ends at 1:00pm

Are you a current active member of Windwood Presbyterian Church: Yes ___ No ___

Emergency Contact and Authorization to pick up Please list local individuals to contact in the event of an emergency, names must match the ID shown.

REL: Relationship to Child (Grandparent, Caregiver, Neighbor)

Legal Name _____ REL: _____ Phone _____

Legal Name _____ REL: _____ Phone _____

Legal Name _____ REL: _____ Phone _____

Legal Name _____ REL: _____ Phone _____

Legal Name _____ REL: _____ Phone _____

Legal Name _____ REL: _____ Phone _____

Parent or Legal Guardian Signature

Date



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I understand that a morning snack will be served. If attending extended care an afternoon snack will also be served.

Parent Initial: _____

Permissions (please circle)

I hereby give / do not give consent for my child to be transported and supervised by the operations employees for (please circle all that apply) Emergency Care Field Trips (Using the School Bus)

I hereby give / do not give my consent for my child to participate in field trips (3 years old and up)

I hereby give / do not give my consent for my child to participate in water activities

(please circle all that apply) Sprinkler Play Splashing/Wading Pools Water Table Play

Parent Initial: _____

Photo Release

From time to time our facility may take photographs for school use. I give/ do not give my consent for the facility to take photographs of my child. Parent Initial: _____

Social Media

From time to time our facility may take photographs or videotape your child for use on the internet for the program's Social media websites: The Adventure Preschool, Kardia Christian Academy, Facebook, YouTube. The child's name will not be used on Facebook or YouTube.

I hereby give / do not give my consent to photograph or videotape my child for Social Media use. (circle)

Parent Initial: _____

Outside Employment

I understand that the staff at this facility are prohibited in participating in outside employment with parents.

Parent Initial: _____

Social Networking with Staff

I understand that the staff at this facility are prohibited in participating in social networking activities with parents or children enrolled at the facility. (Such as Facebook, Twitter, Instagram).

Parent Initial: _____

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

Parent Signature _____ Date _____

Your child is not considered to be enrolled and does not have a slot until the Registration Fees are paid in full.

Two weeks notice in writing is required if you withdraw your child.

There will be a \$25 charge for each class change made after April 1, 2019

We are unable to accept New Students that require an Epipen for severe allergies.

Children in the 4 year old program must be fully potty trained.

Children in the 3 year old program must be potty trained by January 1, 2020

Registration Fees are NON-REFUNDABLE for any reason.

Parent or Legal Guardian Signature

Date



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Authorization for Emergency Medical Care 2019-2020

Authorization for Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take:

Child's Name _____ Date of Birth _____ TO:

Name of Physician _____ Emergency Care Facility _____

Address _____ Address _____

Phone _____ Phone _____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Medical Insurance Coverage: Please complete the following: **Company:** _____

ID# _____ **Group or Account #** _____

We do not have Medical Insurance coverage: _____

Signature of Parent _____ **Date** _____

Special Needs

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, and medication prescribed for long term continuous use, and any other information which caregiver's should be aware of: **If not applicable, initial here** _____

Does your child use an EpiPen for Allergic Reactions? Yes ___ No ___ *(See handbook)*

Signature of Parent _____ **Date** _____

Please attach a current photo of your child.





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Physician's Statement 2019-2020

Name of Child _____ Date of Birth _____

I have examined the above child within the past year and find that he/she is able to take part in the preschool program.

Health Care Professional Name _____

Address _____ City _____ State _____ Zip _____

Health Care Professional Signature _____ **Date** _____

Age > Vaccine √	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	18 mos	19-23 mos	2-3 yrs	4-6yrs
Hepatitis B										
Rotavirus										
Diphtheria, Tetanus, Pertussis										
Haemophilus Influenza type B										
Pneumococcal										
Inactivated Polio										
Influenza										
Measles, Mumps Rubella										
Varicella										
Hepatitis A										
Meningococcal										

TB Test (if required) please circle Positive Negative Date _____

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) _____

Parent Signature _____ **Date** _____

Complete ONLY if Applicable

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official affidavit form developed and issued by the Dept. of Health Services. I understand that this affidavit is valid for 2 years. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

Parent Signature _____ **Date** _____