10555 Spring Cypress Road, Houston, TX 77070
Phone: 281 378 4080 Fax: 281 378 4081

Office Use Only
Reg. #_____ Date_____
Fees paid _____
Check#_____ Cash_____
Paperwork: HF HS SR

Enrollment Form 2020-2021
Elementary
Virtual Learning Program

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

Registration Fees are Non-Refundable for any reason.

Child's Full Name Last:_____First:_____Middle:_____
Date of Birth _____ Child's Age on September 1, 2020:_____ 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. **(8:00am-4:00pm)**
____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday

Before Care: 7:00 am-8:00 am
Mon.____ Tues. ____ Weds. ____ Thurs. ____ Fri.____

Extended Care: 4:00pm-6:00pm
Mon. ____ Tues. ____ Weds. ____ Thurs. ____ Fri. ____

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 _____

_____ _____
Parent or Legal Guardian Signature **Date**

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Child's Name _____

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 Emergency Care
Parent Initial: _____

Photo and Social Media Release
From time to time our staff may take photographs/videos for classroom/school and social media (School websites, Facebook, You Tube, Instagram) purposes. Your child's name will not be used on Social Media.
I Give ____ Do Not Give ____my consent for the staff to take photographs/videos of my child.
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_____

Children that currently attend other schools or are enrolled at The Adventure Prechool or Kardia Academy

My child attends the following school and his/her required immunization record is on file at the school and all the required immunizations and /or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of School:_____Phone #_____

Address of School:_____

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.
New Students that require an Epipen for severe allergies please see handbook for the school policy.

Registration Fees are NON-REFUNDABLE for any reason.

_____ _____

Parent or Legal Guardian Signature **Date**

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Authorization for Emergency Medical Care 2020-2021

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: ___ (*initial)*

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.

The Adventure Program

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Physician's Statement 2020-2021

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 Adventure program.

Health Care Professional Name_____

Address_____ City _____ State _____ Zip _____

Health Care Professional Signature _____Date _____

Age > Vaccine ˅	0-2 mths Date Given	By 3 mths Date Given	By 5 mths Date Given	By 7 mths Date Given	By 16 mths Date Given	By 19 mths Date Given	By 25 mths Date Given	By 43 mths Date Given	By 59 mths Date Given
Hepatitis B									
Rotavirus									
Diptheria, Tetanus, Pertussis									
Haemophilus Influenza type B									
Pneumococcal									
Inactivated Polio									
Influenza									
Measles, Mumps Rubella									
Varicella									
Hepatitis A									
Meningocccal									

TB Test (if required) please circle Positive Negative Date_____

<u>Signature or Stamp of a physician or public health personnel verifying immunization information above</u>.

Or attach a Signed shot record to this form.

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 _____