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

Enrollment Form 2019-2020

Ages 3 months—33 months

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 9:00 am to 2:30 pm.

		Before Care	**After Care**
Monday	_____	**Monday** _____	**Monday** _____
Tuesday	_____	**Tuesday** _____	**Tuesday** _____
Wednesday	_____	**Wednesday** _____	**Wednesday** _____
Thursday	_____	**Thursday** _____	**Thursday** _____
Friday	_____	**Friday** _____	**Friday** _____

Before Care: (Circle) **7:15 am-8:00 am** **8:00 am-9:00 am**
Extended Care: (Circle) **2:30 pm-4:00pm** **2:30pm–5:00pm** **2:30pm-6:00pm**

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 herby 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.

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 : If yes 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										
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_____

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 _____