

ENROLLMENT RECORD



CHILDREN'S PALACE
CHRISTIAN LEARNING CENTERS

Enrollment Information (Please Print)

Child's Name		Name child is called	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Father's Name		Father's Address		Home Phone
Father's S.S. #	Father's D.L. #	Father's Place of Employment	Work Hours	Business Phone
Mother's Name		Mother's Address		Home Phone
Mother's S.S. #	Mother's D.L. #	Mother's Place of Employment	Work Hours	Business Phone
Child lives primarily with <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other _____		How did you hear of Children's Palace? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Flyer	Which Yellow Pages? _____	<input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____
Last Child Care Center Attended				

Attendance Data

Program to Enroll:	<input type="checkbox"/> Monday	<input type="checkbox"/> Full Days	Grade Level (School-age only)	Name of School
Choose the days of the week and the number of hours per day needed MAY NOT CHANGE WEEK TO WEEK	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Up to 5 hours per day	School Phone	Name of Teacher
	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Up to 3 hours per day	Transportation <input type="checkbox"/> Deliver to School <input type="checkbox"/> Pick-up from School	
	<input type="checkbox"/> Thursday	Start Date ____/____/____		
	<input type="checkbox"/> Friday	Withdrawal Date ____/____/____		

Authorized to pick child up from center (List in order of preference to contact in the event of an emergency in which we are unable to contact either parent)

Name	Address	Phone	D.L. #

Emergency Medical Authorizations

	Name	Address	Phone Number
Doctor			
Dentist			
Hospital			

I hereby authorize Children's Palace Christian Learning Centers to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached.

Signature _____ Date _____

I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named doctor cannot respond.

Signature _____ Date _____

I hereby authorize Children's Palace Christian Learning Centers to transport my child to or from school, on educational excursions, or on other center sponsored activities.

Signature _____ Date _____

I hereby authorize Children's Palace Christian Learning Centers to include my child in supervised water activities.

Signature _____ Date _____

I acknowledge receipt of "A Parent's Guide to Day Care".

Signature _____ Date _____

I hereby authorize Children's Palace Christian Learning Centers to use my child's photograph in promotional materials such as Handbooks, Brochures, etc.

Signature _____ Date _____

HEALTH REQUIREMENTS

Name of Child				Date of Birth:	
IMMUNIZATIONS	Date/ dose1	Date/ dose 2	Date/ dose3	Date/ booster	Date/ booster
DPT/TD					
POLIO					
MMR					
HLB					
T.B. Test (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:		
Varicella					
Hep B					
Hep A					
PCV 7					

Signature – Physician or Health Personal _____ Date _____

Signature – Staff Making Handwritten Copy Record _____ Date _____

ADMISSION REQUIREMENT: One of the following must be presented when your preschool age child is admitted to the day care facility or within ONE WEEK of admission. Check to indicate the option you select.

DOCTOR'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

Physician's Signature _____

Date _____

A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

A form or written statement from a health service or clinic.

If you do not have any of the above:

PARENT'S STATEMENT: My child has been examined within the past year by a licensed physician and is able to participate in the day care program:

Name and address of Physician OR address of EPSDT Screening Site

Within the next 12 months, I will obtain a physician's statement, a copy of the medical screening from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility.
OR

My child has an appointment for a physical examination:

Date: _____

Name and Address of Physician OR Address of EPSDT Screening Site: _____

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

Signature – Parent or Legal Guardian _____ Date _____

Note: If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an 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.