

CHILDREN, INC.
NEW ENROLLMENT CHECKLIST

STUDENT NAME _____

TODAY'S DATE _____

NAME OF PROGRAM: Early Learning Center at Walton Verona

PROJECTED ENROLLMENT DATE _____

- Student Data Form
- Child Developmental History Form
- Medical History Form
- Permission for Daily Release Form
- Emergency Information Form/Emergency Authorization
- Publicity Release Form
- Fee Payment Contract
- Current Immunization Form
- Parent Handbook/Policy Guidelines Form

Funding Forms

- Food Form
- United Way
- State

CHILDREN, INC. STUDENT DATA FORM

Center Name _____ Today's Date _____ Enrollment Date _____

Child's Name _____ Nickname _____ Social Security # _____

 Last First Middle
Gender _____ Race _____ Birth date _____ Age _____ Classroom _____

Street Address _____ County _____

City _____ State _____ Zip _____ Home Phone () _____ - _____

Doctor's Name _____ Doctor's Phone Number () _____ - _____

Parent/Guardian #1 _____ SS# _____ Date of birth _____

Place of Employment _____ Position _____ Work Hours _____

Work Phone () _____ - _____ Cell Phone () _____ - _____ Home Phone () _____ - _____

e-mail address _____ Address of Employer _____

Marital Status ___Single ___Married ___Divorced Number in Household _____

Income Bracket: ___ Below \$10,000 ___ \$10,000-14,000 ___ \$15,000-19,000
 ___ \$20,000-29,000 ___ Over \$30,000

Parent/Guardian#2 _____ SS# _____ Date of birth _____

Place of Employment _____ Position _____ Work Hours _____

Work Phone () _____ - _____ Cell Phone () _____ - _____ Home Phone () _____ - _____

e-mail address _____ Address of Employer _____

Emergency Contact #1 _____ () _____

 Name Phone Number Relationship Address

Emergency Contact #2 _____ () _____

 Name Phone Number Relationship Address

Days Attending: M TU W TH F Arrival Time _____ Departure time _____

Employee/Student Status: ___Full Time ___Part time ___Seasonal

For Department Use Only

Tuition _____ Date Received _____ Amount Cash _____ Check _____ Registration fee: ___Yes ___No

Payment Type: ___Full fee ___Discount ___United Way ___State _____ State Worker's Name

 Income UW Co-Pay per day State Co-Pay per day

___CCFP (Food Program) ___Free ___Reduced ___Paid

Immunizations: Up-To-Date Certificate ___Yes ___No _____Date Received _____Exp. Date

CHILDREN, INC.
CHILD DEVELOPMENTAL HISTORY FORM

Child's Name _____ Date _____

Names and ages of siblings _____

Has your child been cared for by anyone other than parents? Yes No By Whom? _____

Has your child previously attended a childcare center? Yes No How Many? _____ For how long?

Where did he or she attend _____

Does your child use the restroom independently? Yes No

Does your child need help dressing or undressing? Yes No

Does your child have any special fears? Yes No Of what? _____

Your child's favorite games _____

Favorite toys _____

Favorite books _____

Does your child dislike any particular food(s)? _____

What form of discipline is used? _____

At what age did your child:

Sleeping Habits:

Walk _____

Hours of sleep _____

Afternoon nap _____

Talk _____

Bedtime _____

Is your child toilet trained? No Yes At what age? _____

Tell us about your child (socially, emotionally, special needs, etc.) _____

What are your hopes for your child as he or she participates in this program?

CHILDREN, INC.,
MEDICAL HISTORY FORM

Child's Name _____

Date _____

Does your child require special medical care, please explain? _____

Does your child have any allergies? ____ Yes ____ No What are they? _____

Does your child have a history of physical impairment? ____ Visual? ____ Speech problems? ____ Hearing?

Current prescribed medications _____

Medical Doctor _____ Doctor's Phone # _____

Physician Group Name & Address _____

Does your child have a medical card or insurance? Name of insurance carrier _____

Medical Card Number _____ Date Issued _____ Date of Expiration _____

Has your child even been to the dentist? ____ Yes ____ No Dentist Name _____

Dentist Group Name & Address _____

Age of child at visit dentist visit? _____ Date of last visit to dentist _____

Dentist Phone Number _____ Any specific dental problems? _____

Please circle any of the following illness your child has had:

Measles Mumps Diphtheria TB Heart Disease Chicken Pox

German Measles Rheumatic Fever Polio Diabetes Kidney Disease

Whooping Cough Epilepsy Other _____

Has your child ever been hospitalized? If yes, explain _____

Other information we should know about medical or dental concerns

Parent Signature

Date

CHILDREN, INC.
PERMISSION FOR DAILY RELEASE FORM

At the end of the day or during the day, my child _____
may be released only to the person(s) indicated below. **Any changes must be pre-approved through the office and provided by the parent/guardian. There will be no exceptions.**

Name	Address	Phone	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

At no time is my child, _____, to be released to the person(s) indicated below:

1. _____
2. _____
3. _____

Parent Signature

Date

CHILDREN, INC.
PUBLICITY RELEASE FORM

Dear Parent/Guardian,

From time to time, there are different organizations, newspapers, TV stations, non-profit agencies, or internal needs to take photos, film the agency or activities and children, or to visit or publicize the program and/or activities of the center.

Name of child

I, the undersigned, hereby consent to the reproduction, publication, and other use of photographs or cinematic image and voice of my child by Children, Inc., in newspapers, TV stations, non-profit agencies or other organizations or businesses.

The undersigned grants the above-mentioned rights without compensation.

Parent/Guardian Signature

Date

CHILDREN, INC
FEE PAYMENT CONTRACT

General Enrollment Information

I, the parent/guardian of _____ agree to enroll my child based on the following attendance schedule:

Please circle all days child will be attending and indicate times below: M Tu W Th F
____ 1/2 day ____ Full day Time of arrival _____ Time of pickup _____

Self-Payment

I agree to pay the Center the fee of _____ per week, payable on Monday for the current week attending.

- I understand that if payment becomes two weeks behind my child my be disenrolled from the center.
- I understand that if my child is absent for any number of days in a week, I will still owe the weekly tuition rate.
- I understand that if my child is absent for sickness or on vacation that I am still responsible for the fee.

Tuition Assistance Program

Number of family members: ____ adults ____ children Total (gross, not net) family income _____

____ I qualify for state funding.

____ I qualify for United Way funding.

- Note: I understand that if the state or United Way tuition assistance program refuses to provide payment for excessive absenteeism, I am responsible for any tuition balance that accrues.

Parent/Guardian

Date