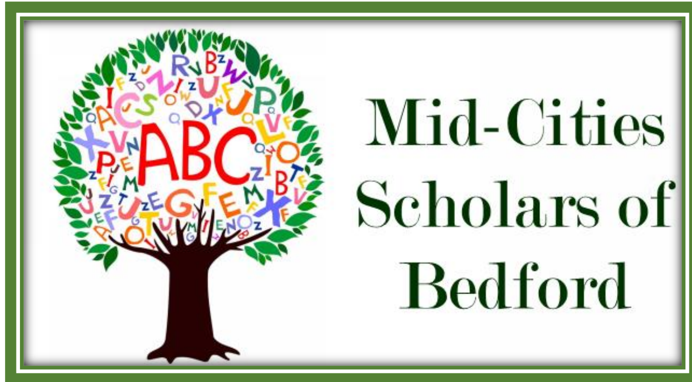

Enrollment Agreement

Completion of this agreement is required for enrollment. This information is necessary for Mid-Cities to comply with state child licensing regulations and to enable us to better understand your child and meet their needs.

Child's Name: ____

Start Date: ____

*Mid-Cities Scholars Return Application Check List. (*Must have all the following before enrollment can start).*

______ Completed Application

______ Immunization Record Included

______ Hearing and Vision Exam included *(Applies to 4 years of age and up)*

______ Healthcare statement Included *(Must be completed by child's physician)*

______ $100 Registration Fee (annual) and $50 supply fee (one-time)

____ ____________________________________

Parent/Guardian Signature Date

Child's Information

Child's Full Name: ____

Address: ____

City: ____ Zip code: ______________________

Age: ____ Date of Birth: ______________________

Phone number: ____________________________________Email: ______________________________

Has your child ever been enrolled in another program? If so where,

____

Days Attendance Mid-Cities Preschool: (Core Knowledge 9-2:30) or Extend Care 6:30-6:00)

Mon Tue Wed Thu Fri Extended Care Core Knowledge

Allergies Please List

Medications: ____Reactions: __________________

Foods: ____ Reactions: __________________

Respiratory: ____Reactions: _____________________

Bee Strings: ____ Reactions: _____________________

Others: ____ Reactions: _____________________

List any special problems that your child may have, such as existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medications prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

____

____

____ ________________________________

Parent/Guardian Signature Date

Parent's Information

Primary Parent/Guardian: ____

Relationship to child: ____

Home Address: ____

City: ____ Zip Code: __________________

Home Number: ______________________________ Cell Phone Number: __________________

Primary Email: ____

Employer: ____

Employer Phone Number: ____

Driver's License Number: ___________________________ DL State: ________________

Secondary Parent/Guardian: ____

Relationship to child: ____

Home Address: ____

City: ____ Zip Code: __________________

Home Number: ______________________________ Cell Phone Number: __________________

Primary Email: ____

Employer: ____

Employer Phone Number: ____

Driver's License Number: ___________________________ DL State: ________________

____ ______________________________

Parent/Guardian Signature Date

Emergency Contact & Release Person (Do not include Parents/Guardian):

Any person picking up that is not immediately recognized will be asked to verify ID with their Driver's License.

In the event I cannot be reached to make arrangements for emergency medical care or to pick up my child, I authorize the below person(s) to take my child to the physician listed on the Health Evaluation portion of this application.

Full Name (1): ___________________________________Relationship to child: _______________________

Home Address: ____

City____ Zip Code: __________________________

Phone Number: ____

DL Number: ____

Full Name (2): ___________________________________Relationship to child: _______________________

Home Address: ____

City____ Zip Code: __________________________

Phone Number: ____

DL Number: ____

Full Name (3): ___________________________________Relationship to child: _______________________

Home Address: ____

City____ Zip Code: __________________________

Phone Number: ____

DL Number: ____

____ ___________________________________

Parent/Guardian Signature Date

Authorization for Medical Attention

I authorize the facility Director or person in charge to take my child to the nearest facility (HEB Hospital) at 1600 Hospital Parkway Bedford TX, 817-685-4000

Children's Primary Physician Name: ____

Address: ____

Phone Number: ____

I hereby give consent for emergency treatment when my child is in the care of this facility/Hospital/Clinic

____ ___________________________________

Parents Signature Date

<table>
<tr><td rowspan="1">CHECK ALL THAT APPLY:
1. TRANSPORTATION:</td><td colspan="2">I hereby give do not give</td><td colspan="2">- consent for my child to be transported and supervised by the operation's employees:</td></tr>
<tr><td>Walk home</td><td>for emergency care</td><td>on field trips</td><td>to and from home</td><td>to and from school</td></tr>
<tr><td>2. FIELD TRIPS:</td><td colspan="2">I hereby give do not give</td><td colspan="2">- my consent for my child to participate in Field Trips:</td></tr>
<tr><td colspan="5">Parent's Comments:</td></tr>
<tr><td>3. WATER ACTIVITIES:</td><td colspan="2">I hereby give do not give</td><td colspan="2">- my consent for my child to participate in Water Activities:</td></tr>
<tr><td></td><td>sprinkler play</td><td>splashing/wading pools</td><td>swimming pools</td><td>water table play</td></tr>
</table>

____ ___________________________________

Parent/Guardian Signature Date

4. RECEIPT OF WRITTEN OPERATIONAL POLICIES:

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

YES NO, I did not receive

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

AM Snack **Lunch (Provide by Parents)** **PM Snack**

Immunization Record

☐ I have provided the childcare operation with a copy of my child's most current immunization record

ADMISSION REQUIRMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must b presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1.☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that the he/she can take part in the day care program.

____ _________________

Healthcare Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐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.

4. ☐ My child has been examined within the past year by a health care professional and can participate in the day care program. Within 12 month of admission, will obtain a health care professional's signed statement and will submit it to the child – care operation.

<u>Name and address of heath care professional:</u>

____

____ ________________________________

Parent/Guardian Signature Date

Vision: R 20/_____________ L20/______________ ☐ Pass ☐ Fail

Signature____

Hearing: 1000Hz 2000Hz 4000Hz ☐ Pass ☐ Fail

Right:

____

Left:

Signature: ____

Mid-Cities Scholars requires applications to be verified and/or updated every 6 months

____ ____________________________________

Parent/Guardian Signature Date