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

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

_____ _____

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.

Name and address of heath care professional:

_____

_____ _____

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