Stepping Stones Preschool

Enrollment Form - 2021-2022

Child's Name____Date of Birth________________________

Child's Address____Home Phone________________________

City, State ____Zip Code__________________________

Date of Admission____Hours in Care___9:00 a.m. - 2:30 p.m.___

Parent's Name____Address, if different_________________

Phone # while child is in care: MOTHER-Business_________________Home________________Cell___________________

FATHER -Business_________________Home________________Cell___________________

Person to call in case of an EMERGENCY if Stepping Stones cannot reach parents and/or guardian:

Name_______________________________________Relationship__________________Phone__________________________

I hereby authorize Stepping Stones to allow my child to leave the child care facility ONLY with the following persons:

	NAME	RELATIONSHIP	PHONE NUMBER	TX DRIVERS LICENSE #
1)	___________________________________	mother________	________________	______________________
2)	___________________________________	father_________	________________	______________________
3)	___________________________________	_______________	________________	______________________
4)	___________________________________	_______________	________________	______________________

INFORMATION IN THIS SECTION IS VERY IMPORTANT AND SHOULD BE COMPLETELY FILLED OUT. THE STATE REVIEWS FILES FOR COMPLETE DATA ON EACH STUDENT ENROLLED IN THE PROGRAM. PLEASE PROVIDE ALL NUMBERS REQUESTED. THANK YOU.

List any special problems that your child may have, such as ALLERGIES, EXISTING ILLNESS, PREVIOUS SERIOUS ILLNESS, INJURIES during the past 12 months, any MEDICATIONS prescribed for long-term continuous use, and any other information which staff should be aware of:

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AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician__________________________Address_______________________________Phone #__________________

Name of Hospital___________________________Address_______________________________Phone #___________________

I give my consent for necessary treatment when my child is in the care of this physician and/or hospital/clinic. I release **Stepping Stones Preschool** and its agents from any liability for any action taken.

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SIGNATURE--Parent OR Legal Guardian

TRANSPORTATION: I hereby [ ] **give** [ ] **not give** my consent for my child to be transported and supervised by facility staff for **field trips**. Initials: _________

IMMUNIZATION: My child's immunization record is on file at **Stepping Stones Preschool** and all immunizations are current. Initials: _________

Updated July 22, 2015

(COMPLETE BOTH SIDES OF THIS FORM)

HEALTH REQUIREMENTS
(A copy of your child's shot record may replace the form below.)

Name of Child____Date of Birth_____________________________

IMMUNIZATIONS	DATE/DOSE 1	DATE/DOSE 2	DATE/DOSE 3	DATE/BOOSTER	DATE/BOOSTER
DPT/TD					
POLIO					
MEASLES: Vaccine-Rubella					
MUMPS: Vaccine					
RUBELLA: Vaccine					
H. I. B.					
CHICKEN POX (Varicella)					
Hepatitis A					
Hepatitis B					
T.B. TEST (if required)	[ ] Positive	[ ] Negative	Date:		

___________________________________Date____________ ___________________________________Date____________
Signature of Staff Completing Chart Record Signature of Physician or Health Personnel

ADMISSION REQUIREMENTS:

One of the following must be presented when your preschool age child is admitted to the child care facility **OR within one week of admission**. Check to indicate the option you select:

1)____ CURRENT copy of an immunization record for each child enrolled in program from a health service or clinic.

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

2)____ **PARENT'S SIGNED STATEMENT**. My child has been examined within the past year by a licensed physician and is able to participate in the child care program (complete blanks in following box):

Name & Address of Physician OR address of Clinic or Screening Site____

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NOTE: Within the next 12 months, I will obtain a physician's statement, or a form or statement from a health service or clinic and will submit it to Stepping Stones Preschool.

OR

3)_____My child has an appointment for a physical examination (complete blanks in following box):

Date________________________Name & Address of Physician____

OR address of Clinic Screening Site____

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

____ ___________________________
SIGNATURE of Parent or Legal Guardian Date

(COMPLETE BOTH SIDES OF THIS FORM)