Ministry of LIGHTHOUSE CHRISTIAN FELLOWSHIP

LITTLE LIGHTHOUSE PRESCHOOL
ENROLLMENT FORM 2019/2020

Denise Traylor, Director
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Phone: 972-562-2906 Fax: 214-544-6967
www.littlelighthousepreschool.org

Child's Name____
Last First Middle

Preferred Name ___________ Sex_____ Date of Birth _________ Age as of 09/01/19______

Father's Name_____________________ Mother's Name ______________________

Home Phone #________________________

Father's Cell _________________________ Mother's Cell ________________________

Primary Email ____________________________ Would you like updates on this email? _____

Home Address_________________________________ City_____________ Zip___________

Mother/Father's Address (if different from above) ___________________________________

Is there another Email where you would like to receive updates ________________________

Can your info be shared in a directory? ______

How many days would you prefer? _____ 2 days (Registration $175– Tuition $225/mo)

Registration Fee is NON-REFUNDABLE _____ 3 days (Registration $225– Tuition $300/mo)

How did you hear about us? ___________ Church Currently Attending ________________

Name & Age of Siblings____

ALLERGIES (see office for form needed from physician): ______________________________________

Special Needs/services, Existing/Previous Illnesses, Injuries, Hospitalizations, or Additional Notes:

____

____

FOR OFFICE USE ONLY:	DAYS ENROLLED:	PAPERWORK:
		_________ Reg. Fee
DATE OF ADMISSION:______________	__________ Tuesday/Thursday	_________ Parent Authorization
	__________ Tuesday/Wednesday/Thursday	_________ Health Form
CHECK #:________ Reg. Amount: ___________		_________ Medical Release _________ Shot Records
DATE OF WITHDRAWAL:______________		_________ Hearing and Vision
	____________________ Class Assignment	

Childs Name: _________________________

Parent Authorization and Acknowledgement

Who can we contact OR release your child to in case of an emergency:
In the event that either parent cannot pick up their child, I authorize Little Lighthouse Preschool to allow my child to leave this facility with the following people. Please include ALL information.

Name___________________________________ Driver's License #_______________
Address_________________________________ Phone Number_________________

Name___________________________________ Driver's License #_______________
Address_________________________________ Phone Number_________________

I. Photographs

As your child participates in the program throughout the year, we would like to take some pictures to put together Memory Books. You can also sign up to receive pictures and videos through the **SeeSaw** app. Your signature gives your consent for your child to be photographed.

Parent Signature____ Date _____________

II. Parent Handbook and Discipline & Guidance

I acknowledge the access to the LLP Parent Handbook with our discipline policies at www.littlelighthousepreschool.org. I will carefully read the rules and policies of the handbook. I agree to abide by these policies and ask for explanations of anything that is not clear to me.

Parent Signature____ Date _____________

III. Nutritional Responsibilities

I acknowledge that meals and snacks are provided by families and the child-care center is not responsible for nutritional value or meeting the child's daily food needs.

Parent Signature____ Date _____________

IV. Health Form and Medical Release

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize **Little Lighthouse Preschool** staff to take my child to an Emergency Room or to the following physician or his/her associated, for medical care.

Child's Physician Name_______________________________ Office Phone#_________________________
Doctor's Office Address____
Hospital Preference____
Medical Insurance Plan__________________________________ Group #__________ Policy #_________ Parent's Signature: _______________________________ Date: _________________________________

Allergies, Special Needs, Existing/Previous Illnesses or injuries, or Hospitalizations, during the past 12mo.
:____

Childs Name: ________________________

4 THINGS NEEDED FROM YOUR PHYSICIAN:

THIS PART NEEDS TO BE SIGNED BY YOUR DOCTOR:

1. MEDICAL RELEASE for ____________________________(child name)

The above named child has been examined by a physician and found to be free of infectious diseases and able to participate in group activities at Little Lighthouse Preschool.

*Doctor Signature:____

*Doctor Printed Name:____

THESE RECORDS CAN BE FAXED BY YOUR DOCTOR:

2. Shot Records:

Please attach a copy of your child's current shot records to this form.
Can be FAXED to us at 214-544-6967

3. Hearing and Vision Requirements for 4 & 5 year olds:

Please attach a copy of child's Hearing and Vision results from physician. Can be FAXED to us at 214-544-6967

4. DOCTOR DOCUMENTED ALLERGIES: **Please see office for required form if applicable**

ALLERGY EMERGENCY PLAN

This plan must be signed and dated by your child's Health Care Professional

Childs name: ___________________________ Date of Birth: ___________________________

Doctor: ____

Address: ____

Phone: _____________________________________ Fax: ______________________________

Please complete one form for EACH KNOWN ALLERGY

Child is allergic to: ____

Possible Symptoms if exposed are: ____

____

Specific Steps to take if child has an allergic reaction: _________________________________

____

By signing below, the parent or guardian of this child gives Little Lighthouse Preschool permission to post the child's allergy for staff and personnel.

Dr. Signature: ____________________________________ Date: _________________________

Parent or Guardian Signature: ________________________________ Date: ____________________

Center Director Signature: ____________________________ Date: _______________________

For licensed center to use:

______ *Allergy plan had been posted in classroom, white board and first aid area*

______ *Allergy plan has been included in emergency evacuation binder*