



ENROLLMENT AGREEMENT

Enrollment Agreement

Redwood Church Preschool

Completion of this Enrollment agreement is required for enrollment, much of the information requested is necessary to comply with state childcare licensing regulations. This information will not be shared with any one outside of the Preschool Office.

Child's Information			
First name	Middle name	Last name	Child's nickname
Birthdate	Age on September 1	Age	Sex
Child's primary language		Does child live with both Parents?	
Child's home address		City	State Zip

Primary Parent / Guardian Information			
First name	Middle name	Last name	Relationship to child
Parent's home address		City	State Zip
Home Phone	Cell Phone	Work Phone	Other
Email Address:	Would you like to be on your mailing list?	Payer only?	Allowed to Pickup?
Employer	Employer address	City	State Zip Work hours

Secondary Parent / Guardian Information			
First name	Middle name	Last name	Relationship to child
Parents Home address (if different from above)		City	State Zip
Home Phone	Cell Phone	Work Phone	Other
Email Address:	Would you like to be on your mailing list?	Payer only?	Allowed to Pickup?
Employer	Employer address	City	State Zip Work hours

Child Emergency Contact and Release Information (do not include parents/guardians)
For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up. Please specify whether a contact is and emergency contact or just allowed to pickup the child .

Contact 1	
First and Last name	Relationship to child
Home phone	Cell phone Work Phone (optional)
Emergency Contact YES NO	Allowed to Pick up child YES NO

Contact 2	
First and Last name	Relationship to child
Home phone	Cell phone Work Phone (optional)
Emergency Contact YES NO	Allowed to Pick up child YES NO

Contact 3	
First and Last name	Relationship to child
Home phone	Cell phone Work Phone (optional)
Emergency Contact YES NO	Allowed to Pick up child YES NO

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. Your child will not be released without prior authorization.

Parent Signature _____ Director Signature _____ Date _____

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Child's Medical Care Provider				
Child's name			Birth date	
Primary physician's name		Primary physician's practice name		Phone
Physician's practice address			City	State Zip
If physician cannot be reached, what action should be taken? <input type="checkbox"/> Call Emergency Hospital <input type="checkbox"/> Other Explain:				
Dentist name		Dentist practice name		Phone
Dentist practice address			City	State Zip

Child's Preadmission Health History – Parents Report				
Height	Weight	Hair color	Eye color	Sex
Has child been under regular supervision of physician? <input type="checkbox"/> YES <input type="checkbox"/> NO			Date of Last Physical/ Medical Examination	
Walked at Months:		Began talking at Months:	Toilet training started at Months:	
Does child have frequent colds? <input type="checkbox"/> YES <input type="checkbox"/> NO		How many in the last year?		
Past illnesses- Check illnesses that child has had and specify approximate dates of illness:				
Date		Date		Date
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps		
Specify any other serious or severe illness or accidents				
List any allergies staff should be aware of				
Daily Routines				
What time does child get up?		What time does child go to bed?		Does child sleep well?
Does child sleep during the day?		When?		How long?
Diet pattern: (What does your child usually eat for these meals)	Breakfast			What are the usual eating hours? Breakfast _____ Lunch _____ Dinner _____
	Lunch			
	Dinner			
Any foods dislikes?		Any eating problems?		
Is child toilet trained? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes at what stage</i>		Are bowel movements regular <input type="checkbox"/> YES <input type="checkbox"/> NO What is usual time?		
Word use for bowel movement		Word use for urination		
Is child presently under doctor's care? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, name of doctor</i>		Does child take prescribed medications? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, what kind and any side effects</i>		
Does child use any special device(s): <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, what kind</i>		Does child use any special device(s) at home? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, what kind</i>		

Parent evaluation of child's personality _____

Has the child had group play experience? _____

Does the child have any special problems/ Fears/ Needs? _____

How does child get along with parents, brothers, sisters and other children? _____

What is the plan for care when the child is ill? _____

Parent Signature _____ Date _____

Consent for Emergency Medical Treatment

As the Parent or Authorized representative, I hereby give consent to **Redwood Church Preschool** to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.) osteopath (D.O) or dentist (D.D.S) for _____. This care may be given under whatever conditions
(name of child)
are necessary to preserve the life, limb or well being of the child name above.
Child has the following medical allergies:

Parents or Authorized representative signature_____
Date_____
Home Address(_____) _____
Home Phone(_____) _____
Work Phone**Child's Medical Immunization Requirement**

Below is a list of immunizations required by the state of California. Please Print Hospital record and turn it in as soon as possible.

Polio (OPV or IPV)**DTP/ DTaP / DT/ TD) Diphtheria****MMR (Measles, mumps, and rubella)****HIB****Hepatitis A****Hepatitis B****Varicella (chickenpox)****Permission Request**

- ☐ **Media Consent**
Occasionally, photos will be taken of the children at the center for use within the center or on our website & for advertising purpose. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.
- ☐ **Walking Excursion**
I give permission for my child to participate in supervised walking excursions near and around the center.
- ☐ **Private Employment Acknowledgement and Release**
Any arrangement / employment between me and staff of this center (babysitting), outside of the program and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Parent Signature _____ Date: _____