



10555 Spring Cypress Road, Houston, TX 77070

Phone: 281 378 4050 Fax: 281 378 4081

Enrollment Form 2017-18

Please PRINT CLEARLY!

Registration Fees are Non-Refundable

Office Use Only	
Reg. # _____	Date _____
Fees paid _____	
Check# _____	Cash _____
Paperwork: HF HS SR	

Child's Full Name Last: _____ First: _____ Middle: _____
 Date of Birth _____ Child's Age on September 1, 2017: _____ Gender: M / F
 Child's Home Address _____ City, State, Zip _____
 Child's Home Phone Number _____ Date of Admission _____

Mother's Full Name _____ Mother's Home Phone Number _____ Mother's Work Phone Number _____ Mother's Cell Phone Number _____ Mother's Address _____ Mother's City, State, Zip _____ Mother's Email Address _____ Place of Employment _____	Father's Full Name _____ Father's Home Phone Number _____ Father's Work Phone Number _____ Father's Cell Phone Number _____ Father's Address _____ Father's City, State, Zip _____ Father's Email Address _____ Place of Employment _____
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Is there a custody order on file with the State of Texas? (circle) YES NO PENDING
**If circled YES, a current copy of your court order must be attached*

Enrolling for: Transition, Kindergarten, 1st Grade, 2nd Grade, 3rd Grade, 4th Grade, 5th Grade, 6th Grade
 (Please circle one)

Before Care: (Circle) 7:15 am-8:15 am
 Mon. ___ Tues. ___ Weds. ___ Thurs. ___ Fri. ___

Extended Care: (Circle) 3:30 pm-4:00pm 3:30pm-5:00pm 3:30pm-6:00pm
 Mon. ___ Tues. ___ Weds. ___ Thurs. ___ Fri. ___

Emergency Contact and Authorization to pick up *Please list local individuals to contact in the event of an emergency*

Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____

Parent or Legal Guardian Signature _____
Date



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If attending extended care an afternoon snack will be served.

Parent Signature _____ Date _____

Permissions (please circle)

I hereby give / do not give consent for my child to be transported and supervised by the operations employees for
(please circle all that apply) Emergency Care Field Trips (Using the School Bus)

I hereby give / do not give my consent for my child to participate in field trips.

I hereby give / do not give my consent for my child to participate in water activities
(please circle all that apply) Sprinkler Play Splashing/Wading Pools

Parent Signature _____ Date _____

Photo Release

From time to time our facility may take photographs for school use. I give/ do not give my consent for the facility to take photographs of my child. Parent Signature _____ Date _____

Social Media

From time to time our facility may take photographs or videotape your child for use on the internet for the program's Social media websites: The Adventure Preschool, Kardia Christian Academy, Facebook, YouTube. The child's name will not be used on Facebook or YouTube.

I hereby give / do not give my consent to photograph or videotape my child for Social Media use. (circle)

Parent Signature _____ Date _____

Social Networking with Staff

I understand that the staff at this facility are prohibited in participating in social networking activities with parents or children enrolled at the facility. (Such as Facebook, Twitter, Instagram).

Parent Signature _____ Date _____

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

Parent Signature _____ Date _____

Your child is not considered to be enrolled and does not have a slot until the Registration Fees are paid in full.

Two weeks notice in writing is required if you withdraw your child.

We are unable to accept New Students that require an Epipen for severe allergies.

Registration Fees are non-refundable.

Parent or Legal Guardian Signature

Date



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Authorization for Emergency Medical Care

Authorization for Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child: Name _____ Date of Birth _____

to:

Name of Physician _____ Emergency Care Facility _____

Address _____ Address _____

Phone _____ Phone _____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

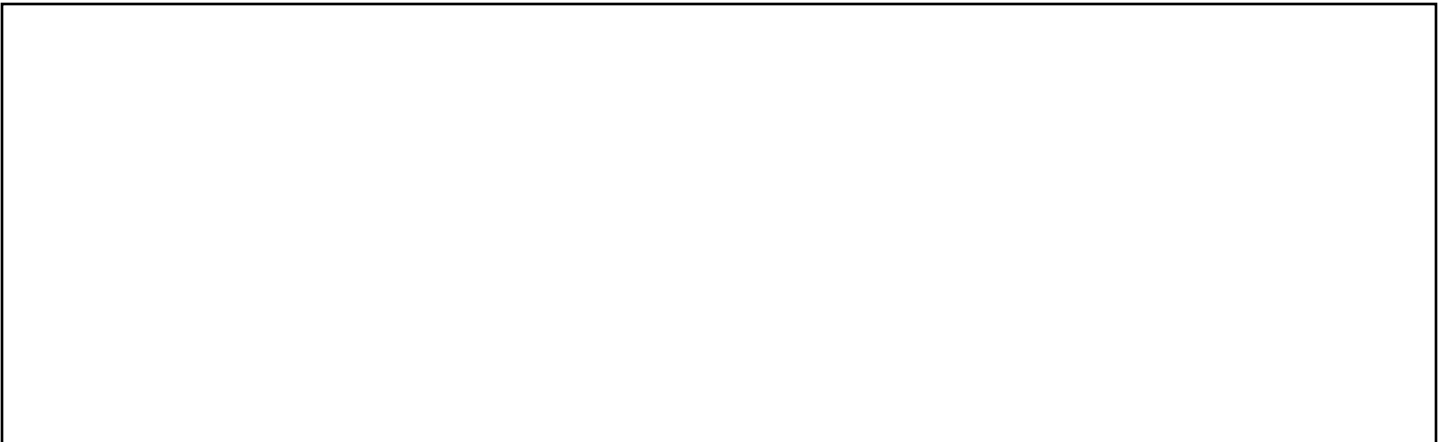
Signature of Parent _____ **Date** _____

Special Needs

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, and medication prescribed for long term continuous use, and any other information which our staff should be aware of: _____
If not applicable, initial here _____

Signature of Parent _____ **Date** _____

Please attach a current photo of your child.





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Physician's Statement

Name of Child _____ Date of Birth _____

I have examined the above child within the past year and find that he/she is able to take part in the preschool program.

Health Care Professional Name _____

Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

Age > Vaccine √	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	18 mos	19-23 mos	2-3 yrs	4-6yrs
Hepatitis B										
Rotavirus										
Diphtheria, Tetanus, Pertussis										
Haemophilus Influenza type B										
Pneumococcal										
Inactivated Polio										
Influenza										
Measles, Mumps Rubella										
Varicella										
Hepatitis A										
Meningococcal										

TB Test (if required) please circle Positive Negative Date _____

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) _____

Parent Signature _____ **Date** _____

Complete ONLY if Applicable

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official affidavit form developed and issued by the Dept. of Health Services. I understand that this affidavit is valid for 2 years. 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.

Parent Signature _____ **Date** _____