10555 Spring Cypress Road, Houston, TX 77070

Phone: 281 378 4050 Fax: 281 378 4081

Office Use Only
Reg. #______ Date_____
Fees paid ______
Check#______ Cash_____
Paperwork: HF HS SR

Enrollment Form 2017-18

Please PRINT CLEARLY!

Registration Fees are Non-Refundable

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_________________________________

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 ___________________

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 herby 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 ______

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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										
Diptheria, Tetanus, Pertussis										
Haemophilus Influenza type B										
Pneumococcal										
Inactivated Polio										
Influenza										
Measles, Mumps Rubella										
Varicella										
Hepatitis A										
Meningocccal										

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 ________________