



Enrollment Form/Child Records

Please fill in application completely and legibly

For Office Use Only:
Date of Registration _____
Date of Termination Status _____

Child's Name

(Last Name)

(First Name)

(Middle Initial)

Child's Address**Child's Address**

(City)

(State)

(Zip Code)

Home Phone #**Date of Birth****Sex M F****Enrolling Parent/Guardian Name**

(Last Name)

(First Name)

(Middle Initial)

Relationship to Child**Address****City/State/Zip****E-mail Address****Home Phone #****Cell Phone #****Employer****Work Phone #****Extension #****Second Parent/Guardian Name**

(Last Name)

(First Name)

(Middle Initial)

Relationship to Child**Address****City/State/Zip****E-mail Address****Home Phone #****Cell Phone #****Employer****Work Phone #****Extension #****Parent's Marital Status** Married Divorced Single**Primary Residence** Both Mother Father Guardian**If divorced, who has legal custody?****May the non-custodial parent pick up the child?** Yes No**The child will be released only to the people on this form and the following persons:****Name****Address****Phone #****Name****Address****Phone #****Name****Address****Phone #****Parent/Guardian Signature**



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How did you hear about us?

(circle all that apply)

Referred Internet Yellow Pages

Direct Mail Ad Other _____

Child's Name

(Last Name)

(First Name)

(Middle Initial)

Child's Physician

Any Allergies or special needs? No Yes, explain:

Emergency contact other than parents

(Name)

(Address)

(Phone #)

2nd Emergency contact other than parents

(Name)

(Address)

(Phone #)

Is your child potty trained? Yes No

Does your child need help with the following? Dressing Eating Washing Hands

Does your child have any special fear or problems?

Has your child ever been cared for by anyone other than the parents? Yes No

If Yes, whom?

Favorite Book

Favorite Toy/Game

Circle days that your child will attend. Monday Tuesday Wednesday Thursday Friday

Arrival Time

Departure Time

Freshwater Learning Center will be open from 6AM to 6 PM.

- I agree that I am enrolling for _____ days per week at a cost of _____.
- I agree to pay the \$35.00 registration fee at the time of enrollment. This registration fee is non-refundable.
- I agree to pay the weekly tuition when it is due.
- I am aware that a two week's absence of paying my tuition dues, FLC may suspend my child's enrollment.
- I am aware that continued delinquent tuition payments will result in the termination of my child's enrollment.
- I am aware that permanent changes to the agreed times and/or days must be submitted to the Director in writing at least *two weeks prior* to the requested effective date. A new agreement will be written and signed at that time. The Director must approve daily changes in advance. Requests will be fulfilled based on availability.

Parent/Guardian Name (please print)

Parent/Guardian Signature

Date

Director Signature

Date



Immunization Record

This form **MUST** be filled out by your child's doctor.

For Office Use Only:
Director Initials _____
Date _____

Child's Name _____

Birth Date _____

Date of Enrollment _____

Gray boxes are not required by law. Black boxes are invalid vaccinations.

Immunization History	1 MM/DD/YY	2 MM/DD/YY	3 MM/DD/YY	4 MM/DD/YY	5 MM/DD/YY
Diphtheria, Tetanus, Pertussis (DTP)					
Polio (IPV and/or OPV)					
Measles, Mumps, Rubella (MMR)					
<i>Haemophilus Influenzae</i> type b (Hib)					
Varicella (Chickenpox)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B (Hep B) <i>Required for kindergarten</i>					

A. For children who are **15 months or older** and who have received all the immunizations required by law for child care:

- I certify that the above named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

Signature of Child's Physician _____

Date _____

B. For children who are **younger than 15 months** or who **have not** received all the immunizations required by law for child care.

- I certify that the above named child has received the immunizations indicated above and:
 - ___ will complete the immunizations required by law for child care within 18 months; and/or
 - ___ immunization is not indicated for medical reasons or laboratory confirmation of adequate immunity exists for the following immunization(s), _____; and/or
 - ___ the parent/guardian is opposed to certain vaccine(s) as indicated by them in Section C below.

Signature of Child's Physician _____

Date _____

C. If the parent/guardian **conscientiously opposes** immunizations:

- I hereby certify by notarization that:
 - ___ I am opposed to all immunizations.
 - ___ I am opposed only to the vaccines indicated and have had my child's physician complete section B above. Vaccine(s) I oppose are: _____

Signature of Parent/Guardian _____

Date _____

Subscribed and sworn to before me this _____ day of _____, 20____

Signature of Notary Public _____

(A copy of the notarized statement will be forwarded to the commissioner of health.)



Notary Public Stamp



Medical Record

This form MUST be filled out by your child's doctor.

For Office Use Only:
Director Initials _____
Date _____

Child's Name _____

Birth Date _____

Date of Enrollment _____

Date of last Physical exam _____

Is the child up to date on their immunizations? Yes No

If no, plan for bringing the child up-to-date? _____

Copy of immunizations attached and signed by health care provider? Yes No

Allergies? Yes No If yes, what allergies does your child have? _____

Does the child have any important health concerns that are followed by another source of health care? (if so, please give the name of provider and condition requiring attention) _____

Does the child have any special needs that require accommodation by the provider? _____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____

Does the child require a different sleep position other than on their back? _____

What is the status of the child's Vision: _____ Hearing: _____ Speech: _____

Is there any other information that would be helpful in a group care setting? _____

Primary health care provider's name _____

Clinic Name _____

Phone # _____

Address _____

(Street)

(City)

(State)

(Zip)

Signature of Child's Physician _____

