Enrollment Form

Please complete entire form, do not leave blanks and PRINT CLEARLY!

Date of Admission ________________ Date of Withdrawal ______________________

Child's Full Name ____ Date of Birth ___________________________

Child's Home Address ____ City, State, Zip ___________________________

Mother's Full Name________________________________

Cell Number ____________________________________

Email ____

Work Number ____________________________________

Place of Employment _____________________________

Address (if different from child) _________________________

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Father's Full Name________________________________

Cell Number ____________________________________

Email ____

Work Number ____________________________________

Place of Employment _____________________________

Address (if different from child) _________________________

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Cell numbers and email addresses are required. Text messages and email messages will be sent to parents for emergency notifications, general information, and reminders. Please update the center when personal info changes.

If your child is ill, which parent and which number should we contact first ____

Custody/Visitation Arrangements if applicable ____

Siblings: Name and date-of-birth of all siblings ____

Emergency Contact: (Please **DO NOT** list a parent)

1. Name_________________________________ Phone________________________ Relationship____________________

Address ____

Student pickup: I authorize my child to be released ONLY to the following persons after verification of ID.

Name____ Phone________________________

Name____ Phone________________________

Name____ Phone________________________

Meals and Schedule: My child will normally be in attendance on the following days: *(circle all that apply)*

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday* and times -- from: ____________ to: ________________ I understand that breakfast, morning snack, lunch and afternoon snack will be served. Check the center's schedule for breakfast serving times. When parents supply lunch from home they are responsible for the nutritional value and safety of the food. **Parent Signature ___________________________________

Locations: Choose the correct location

☐ Discovery Barn Learning Center, 202 Gaines Street, Brazoria, TX 979-798-5696

Director: Carolyn Helm Email: director@discoverybarn.biz

☐ Discovery Days Learning Center, 1320 W. Brazos Ave., West Columbia, TX 979-345-3333

Director: Nichole Siegel Email: nichole@discoverydays.biz

Permissions: *(please circle) We do NOT transport children to their homes or any location other than their school.*

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 To and From School

I hereby ☐ ***give*** / ☐ ***do not give*** consent for my child to participate in **field trips** away from the center.

I hereby ☐ ***give*** / ☐ ***do not give*** permission to apply **sunscreen** to my child as needed.

I hereby ☐ ***give*** / ☐ ***do not give*** permission to apply **mosquito spray** to my child as needed.

I hereby ☐ ***give*** / ☐ ***do not give*** permission to **photograph** my child for art projects, classroom organization and bulletin boards, social media and future publications, such as advertising.

I hereby ☐ ***give*** / ☐ ***do not give*** permission to be released to the care of his or her sibling under 18 years old.

Authorization for Emergency Medical Attention: In the event I cannot be reached, I authorize the person in charge to take my child to: Physician **OR** Emergency Facility ____________________

Address ____________________ Phone ____________________

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

**Parent Signature____________________

Medical Conditions/Special Care Needs: Check all that apply

☐ Environmental Allergies ☐ Food Intolerances ☐ Existing Illness ☐ Previous Serious Illness

☐ Injuries and Hospitalizations ☐ Limitations or restrictions on child's activities ☐ Adaptive Equipment

☐ Symptoms or indications of complications ☐ Medications prescribed for continuous long-term use

☐ Speech Delays ☐ Cognitive Delays ☐ Other: ____________________

Explain any accommodations and/or modifications: ____________________

____

____

Does your child have diagnosed food allergies? (check one) ☐ YES ☐ NO Date Emergency Plan Submitted: ____________

Describe any medications your child takes; how and when it's administered: ____________________

____________________*(Medications administered at the center will require a separate form)*

FOR SCHOOL AGE STUDENTS SKIP TO BOTTOM SECTION

☐ I have provided a copy of the child's most current immunization record (and vision and hearing screening for ages 4+).

☐ If applicable, I have provided an Emergency Medical Form from my child's physician.

☐ My child has been examined within the past year by a health care professional and is able to participate in normal activities without limitations. Within 12 months of admission, I will submit a health care providers signed health statement.

**Parent Signature____________________

School Age Children: My child attends the following school:

☐ Barrow Elementary, 1112 Gaines Street, Brazoria, TX 979-799-1740

☐ West Columbia Elementary, 711 South Gray Street, West Columbia, TX 979-799-1760

☐ Wild Peach Elementary, 3311 CR 353, Brazoria, TX 979-799-1750

☐ Other: ____________________ Address: ____________________ Phone:________________

My child's immunization records, vision and hearing screening are on file at the school and are current.

My child has permission to (circle all that apply) walk ride a CBISD bus ride in the daycare van to and from school.

**Parent Signature ____________________

Water Activities:

I give consent for my child to participate in the following water activities (check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

☐ Yes ☐ No

Do you want your child to wear a life jacket while in or near a swimming pool?

☐ Yes ☐ No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

☐ Yes ☐ No

Receipt of Written Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- ☐ **Discipline and guidance**
- ☐ **Procedures for release of children**
- ☐ **Suspension and expulsion**
- ☐ **Illness and exclusion criteria**
- ☐ **Emergency plans**
- ☐ **Procedures for dispensing medications**
- ☒ **Procedures for conducting health checks(N/A)**
- ☐ **Immunization requirements for children**
- ☐ **Safe sleep**
- ☐ **Meals and food service practices**
- ☐ **Procedures for parents to discuss concerns with the director**
- ☐ **Procedures to visit the center without prior approval**
- ☐ **Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions**
- ☐ **Procedures for supporting inclusive services**
- ☐ **Procedures for parents to participate in operation activites**
- ☐ **Procedures for parents to contact CCR, DFPS, Child Abuse Hotline, and CCR website**

Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

**Parent Signature:______________________________________ Date:________________________________

Health Statement

Physician's Signature is Required

Child's Full Name ______________________________ Date of Birth ____________________

Physician's Name ____________________ Clinic Name ______________________________

Physician/Clinic Address ______________________________ Phone ____________________

Health Concerns: If YES, please provide comments on the line provided; Emergency Medical Forms may also be needed

Allergies ❑Yes ❑No ______________________________

Vision or Hearing ❑Yes ❑No ______________________________

Speech or Language ❑Yes ❑No ______________________________

Physical impairment ❑Yes ❑No ______________________________

Behavior/Emotional ❑Yes ❑No ______________________________

Complications at birth ❑Yes ❑No ______________________________

Special diet or feeding ❑Yes ❑No ______________________________

Other concerns ❑Yes ❑No ______________________________

Prescriptions/Medications ❑Yes ❑No ______________________________

(Medications administered at the center will require a separate form)

I have examined the above child within the past year and find that he/she is able to take part in your program without any limitations. I verify that the immunization information for the child above is correct and current.

****Physician's Signature** ______________________________ Date ____________________

Forms may be returned by fax or email: Choose the correct location

☐ Discovery Barn Learning Center, Email: director@discoverybarn.biz, Fax 979-798-5676 Questions: 979-798-5696

☐ Discovery Days Learning Center, Email: nichole@discoverydays.biz, Fax 979-345-7896 Questions: 979-345-3333

Director/Office Use Only:

☐ Birth - 2 Months: HepB: 1 dose at birth, 2 does 1 month later; 2 months DTaP, Hib, IPV, PCV, RV

☐ 4 months: DTaP, Hib, IPV, PCV, RV

☐ 6 months: DTaP, PCV, (Hib & RV (may be needed, depending on the brand of vaccine))

☐ 9 months: NONE

☐ 12 months: Hib, MMR, PCV, Chickenpox (varicella)

☐ 15 months: Hib, DTap

☐ 18 months: Hep A

☐ 2-3 years: NONE

☐ 4 years: MMR, IPC, DTaP, Varivax and Vision and Hearing Screening