Enrollment Form

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

Discovery Days &
Discovery BARN
LEARNING CENTERS

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) _____

_____

Father's Full Name_____

Cell Number _____

Email _____

Work Number _____

Place of Employment _____

Address (if different from child) _____

_____

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

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

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)*

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 **water activities**

(please circle all that apply) Sprinkler Play Water Table Play

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.

Notes or special instructions: _____

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: List any conditions your child may have, such as allergies, existing illness, previous illness, injuries and hospitalizations during the last 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of: _____

_____

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.

**Parent Signature _____

Health Statement

Physician's Signature is Required

Discovery Days & Discovery BARN
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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