

# Enrollment Agreement

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information										
<b>Child's Information</b>										
Child's first name			Child's middle name			Child's last name			Child's nickname	
Age	Sex	Child's primary language				Parent/guardian/sponsor primary language				
Child's home address					City		State		Zip	
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name			Grade			School phone		
School address				Drop off time				Pick up time		
<b>Family Information</b>										
List family members & pets your child lives with – include first names, relation and ages of siblings										
Parent/guardian/sponsor			Relationship to child			Home phone			Cell phone	
Home address if different from above					City		State		Zip	
Home email			Work email				Work phone			
Employer		Employer address			City		State	Zip	Work hours	
<b>Other</b> parent/guardian/sponsor			Relationship to child			Home phone			Cell phone	
Home address if different from above					City		State		Zip	
Home email			Work email				Work phone			
Employer		Employer address			City		State	Zip	Work hours	
<b>Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)</b>										
Please notify the center if an Emergency Release Contact will pick up your child on a given day. [For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]										
<b>Person #1</b>			Relationship to child			Home phone			Cell phone	
Home address					City		State		Zip	
Home email			Work email				Work Phone			
Employer		Employer address			City		State	Zip	Work hours	
<b>Person #2</b>			Relationship to child			Home phone			Cell phone	
Home address					City		State		Zip	
Home email			Work email				Work Phone			
Employer		Employer address			City		State	Zip	Work hours	
<b>Person #3</b>			Relationship to child			Home phone			Cell phone	
Home address					City		State		Zip	
Home email			Work email				Work Phone			
Employer		Employer address			City		State	Zip	Work hours	

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

**Medical Information**

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks \_\_\_\_\_

**Child's Medical & Developmental History**

- Does your child have any special medical conditions?  No  Yes Explain \_\_\_\_\_
- Does your child have any chronic illnesses?  No  Yes Explain \_\_\_\_\_
- Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
- Does your child have diabetes?  No  Yes *If yes, please attach care instructions from your physician.*
- Does your child have asthma?  No  Yes *If yes, please attach care instructions from your physician.*
- Will medication be administered regularly?  No  Yes *If yes, please attach care instructions from your physician.*
- Does your child have any special dietary needs?  No  Yes Explain \_\_\_\_\_
- Is your child able to fully participate in all activities?  Yes  No Explain \_\_\_\_\_
- Does your child have any physical restrictions?  No  Yes Explain \_\_\_\_\_
- Does your child function at the level of other children in his/her age group?  Yes  No Explain \_\_\_\_\_
- Is your child able to walk  Yes  No
- Can your child communicate his/her needs?  Yes  No
- Does your child need assistance at meal time?  No  Yes Explain \_\_\_\_\_
- Does your child rest during the day?  No  Yes
- Is your child toilet trained?  No  Yes
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.?  No  Yes Explain \_\_\_\_\_
- Does your child require one-to-one care/supervision on a regular basis for a significant period of time?  No  Yes Explain \_\_\_\_\_
- Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting?  
 No  Yes Explain \_\_\_\_\_

**Illness History** (please check all that apply)

<input type="checkbox"/> Vision problems	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sore throats	<input type="checkbox"/> Fainting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Other

Please attach care instructions from your physician for any of these illnesses.

**Disease History** (please check all that apply and add the date)

<input type="checkbox"/> Chicken Pox (Varicella) _____	<input type="checkbox"/> Bronchiolitis _____	<input type="checkbox"/> Botulism _____
<input type="checkbox"/> Measles Rubeola _____	<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Haemophilus Influenza _____
<input type="checkbox"/> Rubella (German Measles) _____	<input type="checkbox"/> Pertussis (Whooping cough) _____	<input type="checkbox"/> Meningococcal Infection _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Rabies _____
<input type="checkbox"/> Scarlet Fever _____	<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Bacterial Meningitis _____

**Allergies** (please list)

<b>Medication Allergies</b>	Reaction	<b>Food Allergies</b>	Reaction
_____	_____	_____	_____
<b>Bee Stings Allergies</b>	Reaction	<b>Respiratory Allergies</b>	Reaction
_____	_____	_____	_____
<b>Other Allergies</b>	Reaction	<b>Are any of these allergies life-threatening?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____		

Please attach care instructions from your physician for any life-threatening allergies.

**Miscellaneous Screenings and Tests** (please check all that apply and add the date of last screening)

<input type="checkbox"/> Vision _____	<input type="checkbox"/> Developmental _____	<input type="checkbox"/> Tuberculosis (PPD) _____
<input type="checkbox"/> Hearing _____	<input type="checkbox"/> Aptitude _____	<input type="checkbox"/> Sickle Cell Anemia _____
<input type="checkbox"/> Speech _____	<input type="checkbox"/> Educational _____	<input type="checkbox"/> Other _____

To the best of my knowledge the information contained above is accurate.  
 Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

Medical Information (continued)			
Child's name		Birth date	
Child's Medical Care Provider			
Primary physician's name		Primary physician's practice name	Phone
Physician's practice address		City	State
Preferred hospital/clinic for emergency care		City	State
Dentist's name		Dentist's practice name	Phone
Dentist's practice address		City	State
Child's Insurance Provider			
Child's health insurance provider name		Policy number	Secondary health insurance provider name
			Policy number
Child's Immunization History <i>(please attach a copy of your child's immunization records – must be on the TN Dept of Health Certificate of Immunization form)</i>			
Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state			
Anthrax	Influenza	<b>Pneumococcal disease</b>	Smallpox
<b>Diphtheria</b>	Lyme Disease	<b>Polio</b>	<b>Tetanus</b>
<b>Haemophilus Influenzae type b (Hib)</b>	<b>Measles</b>	Rabies	Tuberculosis
<b>Hepatitis A</b>	Meningococcal disease	Rotavirus	Typhoid Fever
<b>Hepatitis B</b>	<b>Mumps</b>	<b>Rubella</b>	<b>Varicella (Chickenpox)</b>
Human Papillomavirus (HPV)	Pertussis (Whooping Cough)	Shingles (Herpes Zoster)	Yellow Fever
Additional Medical Policies			
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.			<b>Initial</b> _____
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.			_____
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.			_____
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the <i>Child Emergency Contact and Release</i> .			_____
Emergency Medical Authorization & Consent			
In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , and lastly my physician.			<b>Initial</b> _____
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.			_____
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.			_____
In case of a medical emergency, I will be responsible for the emergency medical expenses.			_____
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.			_____
Additional Medical Policies			
I give my permission to this center to apply diaper cream as necessary to my child.			<b>Initial</b> _____
I understand that I must supply my own diaper cream with a valid expiration date, and it will be labeled with my child's name.			_____
I <input type="checkbox"/> have <input type="checkbox"/> do not have special instructions for the application process. Explanation:			_____
I understand that it is my responsibility to apply sunscreen to my child before coming to school.			_____
I understand that First Friends Preschool will only administer prescription medications. No over-the-counter medication will be given by First Friends Staff. See Parent Handbook for more detailed information concerning administration of medications.			_____

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_



# Enrollment Agreement

First Friends Preschool

## Other Agreements *(continued)*

Child's name

Birth date

## Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center.

Initial  
\_\_\_\_\_

## Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.

Initial  
\_\_\_\_\_

I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.

Information contained in the Family Handbook may be subject to change.

\_\_\_\_\_  
\_\_\_\_\_

## Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement*.

\_\_\_\_\_  
Primary Parent/Guardian/Sponsor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Staff Signature

\_\_\_\_\_  
Date