ADMISSION INFORMATION

GLEN ROSE FIRST UNITED METHODIST PRESCHOOL
PRE-REGISTRATION FORM

411 NE Barnard St Glen Rose, TX 76043
(254) 897-2572
Fall 2020-2021

Child's Name________________________________ Birth date__________________ Present Age_______

Child lives with _____Mother&Father ___Mother ___Father ___Other____

Mother's Name____

Home Address____ Phone __________________________

City____State___________________Zip_________________

Mailing Address____

City____State___________________Zip_________________

Occupation____Employer____________________________

Work Phone__________________Cell Phone_______________________Email _____________________

Father's Name____

Home Address____ Phone _______________________

City____State___________________Zip________________

Mailing Address____

City____State___________________Zip_________________

Occupation____Employer____________________________

Work Phone_________________________E-mail_____________________Cell Phone_____________________

Family religious preference__________________ Church You Attend______________________________

How did you find out about our program? ____

Please check which days your child will attend:

	M-F 9-2:30 $425 a month		**M-W-F 9-2:30** $285 a month		**T-Th 9-2:30** $225 a month
	Extended Care		**Extended Care**		**Extended Care**
	M-F more than 3hrs $15 a day		**M-W-F more than 3hrs** $15 a day		**T-Th more than 3hrs** $15 a day
	M-F less than 3hrs $10 a day		**M-W-F less than 3hrs** $10 a day		**T-Th less than 3hrs** $10 a day
	M-F Bus Fee $60 a month		**M-W-F Bus Fee** $45 a month		**T-Th Bus Fee** $35 a month

Three-Year-Old Class: Must be 3 years old by Sept. 1st
Four-Year-Old Class: Must be 4 years old by Sept. 1st

Polices	Initials
We only pro-rate tuition for the month August. There are no deductions for holidays or partial week attendance.	
I agree to pay current monthly tuition by the 15th of each month. If tuition is late there is a $15 fee. If the tuition is later than the 25th there is a $30 late fee.	
I will not bring may child to school if they have run fever, diarrhea, or vomiting in the last 24 hours.	

$125.00 Non-refundable registration / supply fee

First United Methodist Preschool

Child's Name		Date of Birth	Child's Home Telephone No.
Child's Home Address			
Date of Admission	Date of Withdrawal	Hours and days child will be in care	
Parent's or Guardian's Name		Address (if different from child's address)	
List telephone numbers where parents/guardian may be reached while child will be in care:	Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.
Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:			Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ **TRANSPORTATION:** I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees.
   ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ **FIELD TRIPS:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:
   Parent's Comments:

3. ☐ **WATER ACTIVITIES:** I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:
   ☐ sprinkler play ☐ pools ☐ splashing/wading ☐ swimming pools ☐ water table play

4. ☐ **RECEIPT OF WRITTEN OPERATIONAL POLICIES:**
   I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

AUTHORIZATION FOR EMERGENCY 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 to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

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

____
Signature - Parent or Legal Guardian

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, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
Hepatitis B					
DTP / DTaP / DT					
Hib					
POLIO IPV or OPV					
MEASLES					
MUMPS					
RUBELLA					
Varicella (see below)					
Pneumococcal Conjugate Vaccine					
Hepatitis A					
TB TEST (if required)	☐ 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 disease (chickenpox) on about (date) ____________________ and does not need varicella vaccine.

____ Parent's signature _______________ Date

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.

_______________________________ Health Care Professional's Signature _______________ Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.
3. ☐ 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.

Name and address of health care professional:

_______________________________ **Signature - Parent or Legal Guardian** _______________ **Date**

VISION	R 20/ ________	L 20/ ________	☐ PASS ☐ FAIL
SIGNATURE ______________________________		DATE ______________________________	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE ______________________________		DATE ______________________________		

_______________________________ **Signature – Parent or Legal Guardian** _______________ **Date**