ADMISSION INFORMATION

GLEN ROSE FIRST UNITED METHODIST PRESCHOOL
PRE-REGISTRATION FORM

411 NE Barnard St Glen Rose, TX 76043
(254)396-2235, (254)396-1114
Fall 2022-2023

Child's Name_____ Birth date_____ Present Age_____

Age when entering school_____

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 $450 a month		**M-W-F 9-2:30** $300 a month		**T-Th 9-2:30** $235 a month
	Extended Care		**Extended Care**		**Extended Care**
	M-F more than 3hrs $17 a day		**M-W-F more than 3hrs** $17 a day		**T-Th more than 3hrs** $17 a day
	M-F less than 3hrs $12 a day		**M-W-F less than 3hrs** $12 a day		**T-Th less than 3hrs** $12 a day

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

ADMISSION INFORMATION

Polices	Initials
We no longer 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 1st class day of each month. If tuition is later than the 10th there is a $15 fee. If the tuition is later than the 15th there is a $30 late fee, if later than the 20th, there is a $50 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
and $50.00 second semester 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 ☐☐ splashing/wading pools ☐ 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:

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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 or 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**