



Enrollment Agreement

Hickory Ridge Academy Early Learning Center

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									
Child's Information									
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		
Family Information									
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
Other 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
Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)									
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.]									
Person #1			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
Person #2			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
Person #3			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
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)

Medication Allergies	Reaction	Food Allergies	Reaction
_____	_____	_____	_____
Bee Stings Allergies	Reaction	Respiratory Allergies	Reaction
_____	_____	_____	_____
Other Allergies	Reaction	Are any of these allergies life-threatening? <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
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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
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Child's Immunization History (please attach a copy of your child's immunization records)

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state requirements. You may do this at <http://www.immunize.org/states/> Bold any immunization below that is a requirement.]**

Anthrax	Influenza	Pneumococcal disease	Smallpox
Diphtheria	Lyme Disease	Polio	Tetanus
Haemophilus Influenzae type b (Hib)	Measles	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	Mumps	Rubella	Varicella (Chickenpox)
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. **Initial** _____
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 *Child Emergency Contact and Release*. _____

Emergency Medical Authorization & Consent

- In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician. **Initial** _____
- 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. _____

I give my permission to this center to apply sunscreen and insect repellent to my child. *Please check which products you will permit.* **Initial** _____

I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name. _____

I have do not have special instructions for the application process. _____

Parent initial _____ Staff initial _____ Date _____

Other Agreements (continued)

Child's name	Birth date
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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 _____

