



10555 Spring Cypress Road, Houston, TX 77070

Phone: 281 378 4050 Fax: 281 378 4081

Enrollment Form 2019-20

Please PRINT CLEARLY!

Registration Fees are Non-Refundable

Office Use Only
Reg. # \_\_\_\_\_ Date \_\_\_\_\_
Fees paid \_\_\_\_\_
Check# \_\_\_\_\_ Cash \_\_\_\_\_
Paperwork: HF HS SR

Child's Full Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
Date of Birth \_\_\_\_\_ Child's Age on September 1, 2019 \_\_\_\_\_ Gender: M / F
Child's Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_
Child's Home Phone Number \_\_\_\_\_ Date of Admission \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Father's Full Name \_\_\_\_\_
Mother's Home Phone Number \_\_\_\_\_ Father's Home Phone Number \_\_\_\_\_
Mother's Work Phone Number \_\_\_\_\_ Father's Work Phone Number \_\_\_\_\_
Mother's Cell Phone Number \_\_\_\_\_ Father's Cell Phone Number \_\_\_\_\_
Mother's Address \_\_\_\_\_ Father's Address \_\_\_\_\_
Mother's City, State, Zip \_\_\_\_\_ Father's City, State, Zip \_\_\_\_\_
Mother's Email Address \_\_\_\_\_ Father's Email Address \_\_\_\_\_
Place of Employment \_\_\_\_\_ Place of Employment \_\_\_\_\_

Is there a custody order on file with the State of Texas? (circle) YES NO PENDING
\*If circled YES, a current copy of your court order must be attached

Enrolling for: Developing Kindergarten Skills (DK), Kindergarten, 1st Grade, 2nd Grade, 3rd Grade, 4th Grade, 5th Grade, 6th Grade
(Please circle one)
School Last Attended \_\_\_\_\_
Before Care: (Circle) 7:15 am-8:30 am
Mon. \_\_\_ Tues. \_\_\_ Weds. \_\_\_ Thurs. \_\_\_ Fri. \_\_\_
Extended Care: (Circle) 4:00 pm-5:00 pm 5:00 pm-6:00 pm
Mon. \_\_\_ Tues. \_\_\_ Weds. \_\_\_ Thurs. \_\_\_ Fri. \_\_\_

Emergency Contact and Authorization to pick up Please list local individuals to contact in the event of an emergency
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent or Legal Guardian Signature

Date



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If attending extended care an afternoon snack will be served.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**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 (Using the School Bus)

I hereby give / do not give my consent for my child to participate in field trips.

I hereby give / do not give my consent for my child to participate in water activities  
*(please circle all that apply)*      Sprinkler Play      Splashing/Wading Pools

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Photo Release**

From time to time our facility may take photographs for school use. I give/ do not give my consent for the facility to take photographs of my child.      Parent Signature \_\_\_\_\_      Date \_\_\_\_\_

**Social Media**

From time to time our facility may take photographs or videotape your child for use on the internet for the program's Social media websites: The Adventure Preschool, Kardia Christian Academy, Facebook, YouTube. The child's name will not be used on Facebook or YouTube.

I hereby give / do not give my consent to photograph or videotape my child for Social Media use. *(circle)*

Parent Signature \_\_\_\_\_      Date \_\_\_\_\_

**Social Networking with Staff**

I understand that the staff at this facility are prohibited in participating in social networking activities with parents or children enrolled at the facility. *(Such as Facebook, Twitter, Instagram).*

Parent Signature \_\_\_\_\_      Date \_\_\_\_\_

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

Parent Signature \_\_\_\_\_      Date \_\_\_\_\_

Your child is not considered to be enrolled and does not have a slot until the Registration Fees are paid in full. Two weeks notice in writing is required if you withdraw your child.

**Registration Fees are non-refundable.**

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date



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**Authorization for Emergency Medical Care**

**Authorization for 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: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

to:  
Name of Physician \_\_\_\_\_ Emergency Care Facility \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

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

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

**Special Needs**

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, and medication prescribed for long term continuous use, and any other information which our staff should be aware of: \_\_\_\_\_  
If not applicable, initial here \_\_\_\_\_

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

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

**Please attach a current photo of your child. Please attach a copy of your child's birth certificate**

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



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**Physician's Statement**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

*I have examined the above child within the past year and find that he/she is able to take part in the preschool program.*

Health Care Professional Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

| Age ><br>Vaccine √                | Birth | 1 mos | 2 mos | 4 mos | 6 mos | 12 mos | 18 mos | 19-23 mos | 2-3 yrs | 4-6yrs |
|-----------------------------------|-------|-------|-------|-------|-------|--------|--------|-----------|---------|--------|
| Hepatitis B                       |       |       |       |       |       |        |        |           |         |        |
| Rotavirus                         |       |       |       |       |       |        |        |           |         |        |
| Diphtheria,<br>Tetanus, Pertussis |       |       |       |       |       |        |        |           |         |        |
| Haemophilus<br>Influenza type B   |       |       |       |       |       |        |        |           |         |        |
| Pneumococcal                      |       |       |       |       |       |        |        |           |         |        |
| Inactivated<br>Polio              |       |       |       |       |       |        |        |           |         |        |
| Influenza                         |       |       |       |       |       |        |        |           |         |        |
| Measles, Mumps<br>Rubella         |       |       |       |       |       |        |        |           |         |        |
| Varicella                         |       |       |       |       |       |        |        |           |         |        |
| Hepatitis A                       |       |       |       |       |       |        |        |           |         |        |
| Meningococcal                     |       |       |       |       |       |        |        |           |         |        |

TB Test (if required) please circle 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 (chickenpox) on or about (date) \_\_\_\_\_

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Complete ONLY if Applicable**

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

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_