Application Form

Spring 2019

Rural Shade Mother Day Out and Learning Center

Personal Information

Child's Name:

Address:

Date of Birth:

Contact telephone numbers

Parent/s or Guardian/s Name: ____

Home #: __________________________

Work # __________________________

Mobile # _________________________

Parent/s or Guardian/s Name: ____

Home #: __________________________

Work # __________________________

Mobile # _________________________

Alternative emergency contact: ____________________

Relationship with child:_________________________

Authorised alternative person to collect child from school: __________________

Contact number:__________________________

Enrollment details

Proposed start date: ______________________________

MDO/Learning Center Session
Tuesday ☐ *Thursday* ☐

Fees:

4 year old class: 35.00 per day

3 year old class: 30.00 per day

1-2 year old class: 30.00 per day

Parent/Guardian Consent

The following section requires your signature in order that we may ethically and legally provide the most comprehensive service to your child. Please read carefully and tick the appropriate boxes.

Do you consent to learning and behavioural data being collected pertaining to your child's ongoing learning and development? Yes ☐ No ☐

Do you consent to your child attending supervised outings to the local park and library?
Yes ☐ No ☐

In the event of your child suffering a high temperature we will of course make contact with you. However; do you consent to the administration of a fever reducer?
Yes ☐ No ☐

In the event of a medical emergency, do you consent to your child being transported to the nearest hospital?
Yes ☐ No ☐

Acceptance

I/We hereby consent to the practices and procedures as detailed above and commit to provide *one month's notice of withdrawal from Rural Shade MDO/Learning Center. We enclose one month's fee in advance and one month's fee as a registration cost.

Signed:________________________ and _______________________ Date:_____________________

All cheques payable to Rural Shade Baptist Church or pay online at givelove.com (click on give and select MDO)

Please post to: 3304 CR 2274, Cleveland, TX 77327
Tel 281-592-6331 Email: ruralshademdo@gmail.com Web www.givelove.church

Rural Shade Mother's Day Out & Learning Center

Church Office: (281)592-6331

PLEASE HELP US GET TO KNOW YOUR CHILD BETTER

Child's Name___________________________ Nickname___________________________

Brothers and Sisters (names & ages):____

____

• Has your child had previous group or preschool experience?___________________________

• Special skills and favorite pastimes?____

• Does your child have any allergies?__________ If yes, please explain.

____

• Are there any medical problems that we should be aware of?___________________________

• Are there any special food or eating instructions?_______________________________________

• Are there any sleeping or napping instructions?____

• Is your child afraid of anything?___________________________________

If so, how are you dealing with it?____

• Has your child had any traumatic experiences, such as moving, death of a loved one or a pet, serious illness, separation, etc.?____

• Is your child usually (please circle): Active Quiet Aggressive Shy

• Have you detected or suspected any difficulties in (please circle):

Hearing Sight Speech Other

• Please give any additional information which you feel might help us better understand and minister to your child on the back of this page.

This information is for the CONFIDENTIAL use of the teachers who will be working with your child. Parent conferences can be easily arranged if there is a problem or a concern that you would like to discuss.

Rural Shade Mother's Day Out & Learning Center

Medical Statement

(Required the first day child is in attendance)

Name of Child____
Birthdate_______/________/________

Parent's Name____

Address____
Phone_______________________

** Any child who appears ill upon arrival shall not be admitted for the day. It is also important that the parent authorize the physician to accept any call from Rural Shade Baptist Church in the event that emergency care is required.

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To be completed by Physician

Dates of completed Immunizations:

Hepatitist B ___________________ ____________________

Hepatitist A ___________________ ____________________

IPV ___________________ ____________________

MMR ___________________ ____________________

DTaP ___________________ ____________________ ________________

HibCV ___________________ ____________________ ________________

Pneumococcal_____________ _____________ ____________ _____________

Varicella

Allergies____

Medication Given ______________________________ Dosage_________________________

History of Convulsions?_________ If yes, please explain.

____
Medication prescribed on a regular basis____
Additional Comments____

____
The child above is physically able to participate in a Mother's Day Out Program.

(Physician's Signature) (Date)

_______________________________________ ____________________

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Permission for Health Care

Please make sure to fill in all spaces, including but not limited to Physicians address and phone number.

Child's Name________________________________ Date______________________

Child's Physician________________________________ Phone # (___)________________
Address ____

Child's Dentist__________________________________ Phone # (___)________________
Address____

Authorized Adults____

In the event of an emergency, please indicate your name and phone number where you and another person can be reached.

Father's name__________________________________ Phone # (___)________________
Mother's name__________________________________ Phone # (___)________________
Another authorized person_________________________ Phone # (___)________________
Address____

FIRST AID

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

Parent Signature________________________________ Date________________________

EMERGENCY CARE

In the event of an emergency in which I cannot be reached, the physician listed above, and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Parent Signature________________________________ Date_______________________

If you are unable to contact the physician listed above, I authorize the available physician, dentist or hospital representative to provide any emergency care deemed necessary for my child.

Parent Signature__________________________________ Date______________________

HEALTH RECORD TRANSFER

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

Parent Signature_______________________________ Date____________________
Name of Health Insurance Company____
Identification #_______________________________