Rev. June 2013

Enrollment Information

Escuelita del Alma, Inc. **3109 IH-35, Austin, TX 78722** **Ph. 512-474-4702** **Armandina Flores, Director**

Child's Name: (First)____________________________ (Middle)_________________________(Last)______________________________

Date of Birth: _____________________ Date of Admission: _______________ Hours/Days in Care:_____________

Child's Address: _____________________________________City:_____________ Zip Code:__________ Home Phone:_______________

Parent/Guardian Name: ________________________________Email Address (print legibly): ___________________________________

Address: ____ City: ___________________ Zip Code: ________ Hm. Ph.:_____________

Name & Address of Place of Employment: ____

Wk. Ph.(ext.): __________________ Cell Ph.: __________________ Other : ___________________

Parent/Guardian Name: _________________________________Email Address (print legibly): __________________________________

Address: ____ City: ___________________ Zip Code: ________ Hm. Ph.:____________

Name & Address of Place of Employment: ____

Wk. Ph.(ext.): __________________ Cell Ph.: _______________________ Other: _______________________

Other persons to contact in case of illness or emergency (if Center can't reach parents/guardian):

1. Name: ________________________________ Address: _____________________________________ wk#___________ cell#________

2. Name: ________________________________ Address: _____________________________________ wk#___________ cell#________

3. Name: ________________________________ Address: _____________________________________ wk#___________ cell#________

I hereby authorize the Escuelita del Alma to allow my child to leave the facility **ONLY** with the following other persons. **Picture identification must be presented to staff at time of pick-up**. It is suggested that parent call the Center or leave a written message for staff ahead of time on days when the child will be picked-up by someone on this list. ***If you have a person picking up your child who is not on the pick up list you must provide a signed note, a phone call and your pick up person must have valid photo identification.

1. Name: _______________________ Address: _____________________ City: ____________ Zip Code:_____ ID#___________________

Wk. Ph.: ___________________ Cell Ph.: _______________________ Other: _______________________

2. Name: _______________________ Address: _____________________ City: ____________ Zip Code:_____
ID#___________________

Wk. Ph.: ___________________ Cell Ph.: _______________________ Other: _______________________

3. Name: _______________________ Address: _____________________ City: ____________ Zip Code:_____
ID#___________________

Wk. Ph.: ___________________ Cell Ph.: _______________________ Other: _______________________

4. Name: _______________________ Address: _____________________ City: ____________ Zip Code:_____
ID#___________________

Wk. Ph.: __________________ Cell Ph.: ______________________ Other: ______________________

List any special problems that your child may have, such as allergies, existing illnesses, previous serious illnesses, injuries during the past 12 months, any medication prescribed for long-term continuous use and any other information which staff should be aware of (**write none and initial if no special problems exist**):____

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AUTHORIZATION FOR MEDICAL EMERGENCY ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Escuelita del Alma, Inc., staff to take my child to:

Physician Name: __________________________ Address:__________________________ City:___________ Phone:_____________

Hospital Name ___________________________ Address:__________________________ City:___________ Phone:_____________

I give consent for emergency treatment when my child is in the care of this physician and/or hospital. I will pay medical cost.

Signature: ____ Date: ________________

TRANSPORTATION: I hereby ( ) give ( ) do not give my consent for my child to be transported and supervised by facility's staff:

( ) on field trips ( ) to and from home ( ) to and from school

WATER PLAY/SPLASH ACTIVITIES: I hereby ( ) give ( ) do not give my consent for my child to participate in water activities/splash day at Escuelita del Alma.

SCHOOL AGE CHILDREN: My child attends the following school and his/her immunization record is on file at the school and all immunizations and tuberculosis test results are current.

School Name:___________________________ Address:__________________________ City:___________ Phone:_______________

Within the next two weeks, I will obtain a doctor's statement, a copy of the medical screening form from the EPSDT program, or a form or statement from a health service or clinic and will submit it to the day care facility.

( ) My child has an appointment for a physical examination:

Name of Physician or indicate the EPSDT Screening Site:

______________________________Address:_______________________ City:___________ Phone:____________ Date:_______

I will submit the physician's statement, EPSDT form, or health service or clinic form to the day care facility following the examination.

*****Note**: If medical diagnosis and treatment and/or immunizations conflict with your religious beliefs, you must present an original, sealed affidavit for exemption that has been approved by the State of Texas Department of health.

I hereby acknowledge that I, the legal guardian, completed all of the above information.

Print name: ________________________________ Signature: _______________________________________ Date: _____________

FOR OFFICE USE ONLY

	Date:	Amount Pd.	Initials
Registration Fee:	_______	_______	_______
Supply Fee:	_______	_______	_______

Deposit: _______ _______ _______