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: _____

Address: _____ City: _____ Zip Code: _____ Hm. Ph.:_____

Name & Address of Place of Employment: _____

Wk. Ph.: _____ Cell Ph.: _____ Other : _____

Parent/Guardian Name: _____Email Address: _____

Address: _____ City: _____ Zip Code: _____ Hm. Ph.:_____

Name & Address of Place of Employment: _____

Wk. Ph.: _____ 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**):_____

_____

_____

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

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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:	_____	_____	_____