



Enrollment Packet Checklist

- Registration Information
- Child Information
- Child Health History
- Liability Release
- Emergency Medical Treatment Authorization
- Payment Information
- Current Health Exam signed by Physician
- Current Immunization Records

Date Received Completed Enrollment Packet _____

Early Childhood Director Signature _____



Registration Information 2011

Child's Full Name _____ Age _____

Child's Sex _____ Birth Date ____/____/____ Preferred Name _____

Parents/Guardians _____

Address _____ City _____

State _____ Zip _____ Home Phone _____

Cell (_____) _____ Cell (_____) _____

Email _____

Parent/Guardian Employer _____ Phone _____

Parent/Guardian Employer _____ Phone _____

Emergency Contacts and Approved Family Release

Name _____ Relationship to Child _____

Phone _____ Release to Pick up Child YES NO

Name _____ Relationship to Child _____

Phone _____ Release to Pick up Child YES NO

Name _____ Relationship to Child _____

Phone _____ Release to Pick up Child YES NO

Child's Doctor _____ Phone _____

In the event of an emergency, may we contact the doctor you have designated if none of the above can be reached? YES NO



Child Information 2011

Child's Full Name _____ Nickname _____

Child's Eating Habits: Typical Picky Eater Special Diet

Sleeping Times: Waking _____ Nap(s) _____ Bed _____

Does your child have any fears or intolerances? _____

Does your child have any nervous habits? How does he/she display them? _____

Is your child completely toilet trained? _____

Has your child had any previous group experience? _____ What type? _____

Child's usual playmates: Girls Boys Alone Older Younger

What kind of play does he/she prefer? _____

What are some of your child's favorite toys, books, activities? _____

Are there any areas you feel require particular attention? _____

Does your child have any pets? Yes No Names of pet(s): _____

Is there any further information that might be helpful in understanding your child? _____



Child Health History

Child's Full Name _____ DOB _____

Does the child have a doctor? Yes No Date of last well child exam _____

Name of Physician or Clinic _____ Telephone _____

Does the child have a dentist? Yes No Date of last exam _____

Name of dentist _____ Telephone _____

Does child currently take any medication? Yes No

If yes, what _____ how often? _____

	Y	N		Y	N		Y	N
Allergies			Seizures			Hepatitis B		
Asthma			Tuberculosis			Rotavirus		
Anemia			Polio			Jaundice		
Serious Accident			Measles			Frequent Cough		
Serious Illness			German Measles			Frequent Sore Throat		
Surgery/ Hospitalization			Mumps			Eczema or Skin Problems		
Diabetes			Meningitis			Stomach Pain		
Heart Disease			Whooping Cough			Diarrhea/Vomiting		
Liver Disease			Scarlet Fever			Problems w/ Urinating		
Hemophilia			Rheumatic Fever			Impetigo		
Sickle Cell Disease			Chicken Pox			Hearing Problems		
Epilepsy			Hepatitis A			Vision Problems		

Please explain any "Yes" answers (include date and age of child) _____

Developmental Disability	Y	N
Does child have any suspected developmental delays?		
Does child require any special braces or adaptive equipment?		

Please explain any "Yes" answers (include date and age of child) _____

Smoke Exposure	Y	N
Is your child exposed to second hand smoke?		
Is tobacco currently in use in your home? (i.e. smokeless tobacco, cigars, cigarettes)		

Nutrition	Y	N
Does child take vitamins, minerals, or Fluoride at home?		
Has child been weaned from the bottle? (When) _____		
Does child ever eat non-food items such as dirt or paint?		
Does child require a special diet?		

Food Allergies _____

Other Allergies _____

Oral Health	Y	N
Does parent help child brush teeth? How often? _____		
Does child use Fluoridated toothpaste when brushing?		
Does child have any untreated tooth decay?		
Does child use a bottle or take a bottle to bed?		
Does child snack on sweets or soda pop? How often? _____		
Has child ever had a bad experience with the dentist?		

Other/Comments _____

Parent/Guardian Signature _____ **Date** _____



LIABILITY RELEASE (RELEASE OF ALL CLAIMS)

I, the undersigned parent(s) or legal guardian(s) for _____ do hereby release, forever discharge and agree to hold harmless Oasis Mother's Day Out and the representatives thereof from any and all liability, claims, or demands for personal injury, sickness, or death, as well as property damage and expenses of any nature whatsoever which may be incurred by my child in the course of participation in **Oasis Mother's Day Out services and related activities**. I understand that there are certain risks inherent at Oasis Mother's Day Out services and activities. I give my child permission to participate in these activities and participation is on a voluntary basis only.

I have been made aware of the scheduled activities and agree to assume all responsibility for any of the previously mentioned occurrences. I give authorization for Oasis Mother's Day Out to provide all necessary food and, if necessary, transportation. I give permission for my child to participate in the aforementioned activities and for any representative of Oasis Mother's Day Out to obtain necessary medical treatment. I assume responsibility for any medical bills incurred as Oasis Mother's Day Out does not carry insurance to cover such expenses. On the registration form, I have disclosed any medical concerns or medications for my child which could be of concern on this outing and certify that it is true and accurate to the best of my knowledge. I give my permission to Oasis Mother's Day Out to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests, if necessary. I understand that every effort will be made to contact me prior to any treatment. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the church to secure and administer treatment, including hospitalization for my child. I also consent to having my child's photograph and/or video used in future promotional literature/marketing materials, web-site and center galleries, or educational presentations.

Should my child have to be removed from the center for medical or disciplinary reasons, I hereby assume any costs incurred. I also understand that disciplinary infractions may result in my child being barred from remaining activities without refund.

Print Child's Name(s)

Parent/Guardian Signature

Date

Emergency Contact, Relationship and Cell Phone Number



Emergency Medical Treatment Authorization
Permission for medical care in parental absence

Child's Full Name Birthdate
Name child answers to

I, parent or guardian of the child named above give my permission to Oasis Mother's Day Out, child care provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it is necessary to have the following information:

Name of Parent or Legal Guardian:
Address:
Home Phone: Work Phone:

Name of Parent or Legal Guardian:
Address:
Home Phone: Work Phone:

Doctor:
Doctor's Address:
Doctor's Phone:

Preferred Hospital to Contact:
Address:
Phone:

Person(s) to be contacted in emergency if the parents are unavailable:

Name: Relationship:
Home Phone: Work Phone:

Name: Relationship:
Home Phone: Work Phone:

Present Medication(s):
Known Allergies:
Date of last tetanus: Insurance:

Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date:



Payment Information

Payment is due on the 1st of every month. If payment is not received by the 5th of the month, a 25% late fee will be charged. If payment is not received, your child's spot will be immediately forfeited. Checks and credit card payments that have been returned by the bank will be charged a \$30.00 NSF fee. A 30 day notice is due if you plan to leave the program or reduce your days. Otherwise, charges are applied.

Monthly Statements will be sent home on the last business day of each month.

Mother's Day Out	One Child	Two Children
Two-Days:	\$50.00 per week	\$100.00 per week
One-Day:	\$30.00 per week	\$60.00 per week

*A non-refundable Enrollment Fee of \$75.00 per child is due at the time of enrollment.

Program

Mother's Day Out

First Preference Monday Tuesday Wednesday Thursday
 Second Preference Monday Tuesday Wednesday Thursday

Enrollment Fee Payment

Cash Check (make out to Oasis Church) Credit/Debit Card

Debit/Credit Card # _____ Exp. Date _____
 Name on Card _____ CVN Code _____
 Billing Address _____
 City _____ State _____ Zip Code _____ Phone _____
 Amount Authorized \$ _____ Authorized Signature _____

For Office Use Only:
 Enrollment Fee Amount _____
 Date Received _____
 Check Number _____ or CC xx _____