

Wee Disciples Lutheran School and Childcare at Trinity Lutheran
Childcare-Preschool-Kindergarten-First Grade-After School Program
1226 1st Avenue North Great Falls, MT 59401
(406) 771-7882 (406) 799-4480
REGISTRATION FORM 2014-15

Child's Name: _____ Phone #: _____

Address: _____

Age: _____ Date of Birth: _____

Food allergies: _____

Describe any special needs, physical conditions, disabilities, allergies or current medications:

Other matters you feel are important: _____

Mother's Name: _____ Social Security Number: _____

Address: _____

Phone # _____

Employer: _____ Phone #: _____

E-mail address: _____

Father's Name: _____ Social Security Number: _____

Address: _____

Phone # _____

Employer: _____ Phone #: _____

E-mail address: _____

Physician Name: _____ Phone#: _____

Emergency Contact _____ Phone #: _____
(other than parent)

Relation to child: _____

Please indicate if you would like the above information included in a Wee Disciples Directory. Yes__ No__

Please enroll my child in the following program(s)

Child Care _____ Preschool M-W-F (_____ A.M. _____ P.M. _____)
Preschool T-TH _____ (A.M. _____ P.M. _____)
Kindergarten _____ First Grade _____ After School Care _____ School attending _____
T-shirt size: _____ Small _____ Medium _____ Large

We at Wee Disciples want your child's time with us to be the most enjoyable experience it can be. In order to do this, we need to know as much about your child as possible. Some things we would like to know are:

With whom does child reside? _____

What is your church preference and has your child been baptized? _____

What is his/her favorite game? _____

What is her/his favorite activity? _____

What are his/her favorite vegetable, meat, and fruit? _____

What are her/his least favorite vegetable, meat, and fruit? _____

How many naps does he/she take and for how long? _____ Nap routines? _____

Which days of the week do you intend for your child/ren to attend? _____

Will they be here all day? _____

At what time do you expect to arrive in the morning? _____

At what time do you expect to pick up your child/ren? _____

Language(s) spoken/ Language interest at home: _____

Are there cultural or family customs, rituals, or traditions that will help us make your child's experience more meaningful?

What is your style of guidance and discipline? _____

Infant/Toddler Intake Information

Age child began sitting ___ crawling ___ walking ___ talking ___

Child eats with: spoon ___ fork ___ hands ___ other ___

Naps per day: ___ At what times are they taken? _____

Has your child been in the care of someone other than yourself? _____ If yes, whom and for how long? _____ Does your child experience any difficulty separating from you? _____

Please tell us how best to calm your child: _____

How do you handle times of day child may be fussy? _____

Is your child toilet trained? Please describe his/her needs if currently training. _____

CONTRACT

I the undersigned parent or legal guardian of _____, do hereby understand and agree to adhere to all policies and guidelines set forth in the Wee Disciples Lutheran School and Daycare manual. I also consent to the following: In the event of sickness, accident, or injury to my child while he/she is in the care of Wee Disciples, if I cannot be contacted immediately, this agreement shall constitute consent to provide emergency medical care to my child by a hospital, medical facility, or physician as shall be determined by the medical caregiver.

My child may participate in field trips, and when necessary, travel in the vehicles driven by Wee Disciples personnel or by public transportation. My child's pictures may be taken and name used in news releases, media accounts of activities and picture projects produced for families, which take place within Wee Disciples.

I will Notify Wee Disciples, (771-7882), between 7:00 AM and 10:00 AM when my child will not be attending for the day and notify immediately when my child will be leaving the program for more than (3) days. If my child is absent five (5) consecutive days without explanation, he/she will be dropped from the enrollment. I will forfeit my deposit and my child will need to reapply in order to return to the center.

Payments are due on the 1st and the 15th of each month. There is a 5 day grace period. On the 6th day, a \$10 per day late fee will be added to your account. If payment is not received on or before the 8th day after payment is due, you will be unable to bring your child to school or daycare until payment is received in full. Any payments received on the 8th day will be cashed that same day. If funds are insufficient, you will be asked to come and pick up your child immediately and a \$30 charge will be added to your account. **No Exceptions!**

I will assume the on-going responsibilities to:

- Sign my child/children in and out each day.
- Communicate regularly with the staff regarding my child's needs.
- Mark all clothing and bedding my child brings to Wee Disciples with their name.
- Provide my children with adequate outdoor clothing.
- Provide extra clothing for my children in case of spills or accidents.
- Assure that my child arrives in good physical health with clean underclothing and is not in need of bathing.

Wee Disciples will:

- Assume responsibilities with respect to the safety and health of my child according to public policy and the laws of the State of Montana.
- Provide meals in accordance with Child & Adult Care Food Program.
- Meet federal and state requirements for child care centers.
- Provide child care services from 7:00 AM to 6:00 PM, Monday through Friday (except major Holidays: New Years' Day, Memorial Day, 4th of July, Labor Day, Good Friday, Thanksgiving, the day after Thanksgiving, Christmas holiday).
- Provide Preschool services during times specified
- Notify me two weeks in advance if childcare is to be discontinued.

AUTHORIZATION TO RELEASE

I, _____, the undersigned do solemnly swear that I am the legal parent or guardian of _____ . I authorize Wee Disciples to release my child to the following persons.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We will ask for a photo ID for people we do not recognize. Children will not be released to any one that does not have prior written authorization to pick up your child.

I agree to pay the fees as described in the handbook. I understand the fee agreement and agree to pay all charges incurred during any stay my child or children have at Wee Disciples Lutheran School and Daycare according to the handbook and as stated in the above contract. Should my account be referred to collections, I understand that interest will accrue at the rate of 10% per annum and I agree to pay the interest rate as it is allowed by law. I further agree to pay any additional court costs, collection fees and attorney fees reasonable with all the costs and expenses incurred to collect my debt.

Signature _____ Date: _____
Father or/Legal Guardian's Signature

And

Signature _____ Date : _____
Mother/Legal Guardian Signature

Signature _____ Date : _____
Wee Disciples' Representative

The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities on the basis of race color, national origin, gender, religion, age, disability or political beliefs. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact the USDA's TARGET Center at (202) 720-2600 (voice and TDD) To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SE, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ Birth Date: _____

Address: _____

Mother / Legal Guardian's Name: _____ Home Number: _____

Address: _____ Cell Number: _____

Work Address: _____ Work Number: _____

Father / Legal Guardian's Name: _____ Home Number: _____

Address: _____ Cell Number: _____

Work Address: _____ Work Number: _____

Emergency Contact Person: _____ Contact Number: _____

Emergency Contact Person: _____ Contact Number: _____

Physician / Medical Care Source: _____ Contact Number: _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ Name: _____

Name: _____ Name: _____

WRITTEN CONSENT IS GIVEN FOR:

Yes No EMERGENCY MEDICAL CARE

ADMINISTRATION OF PRESCRIPTION MEDICATIONS **Medication Authorization form and Medication Administration Log Must be completed**

ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS **OTC Medication Authorization Form and Medication Administration Log must be completed**

ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

TRIPS: Yes No TRANSPORTATION BY THE FACILITY FOR TRIPS

Yes No DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

| | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|--------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Hay fever, asthma, or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Chickenpox | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema or frequent skin rashes | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Trouble with passing urine / bowel movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart condition | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds, sore throats, earaches, tonsillitis, pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |

Allergies or reaction: (food or other) YES NO

Please Explain:

Other Health Concerns (special disabilities): YES NO

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN

DATE