**Little Seedlings Preschool Enrollment**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents

Tuition $450 a month

Registration/Deposit $ 525 Date

\_\_\_\_\_ General Family Information & Photo Consent

\_\_\_\_\_ Health Information (Physical Exam & Medical Information)

\_\_\_\_\_ Medical Consent for Emergency Treatment

\_\_\_\_\_ Immunization Record

\_\_\_\_\_ Financial Agreement

\_\_\_\_\_ Parent Handbook

Note:

**General Family Information**

Child’s Name: Date of Birth:

Child’s Primary Residence:

Home Phone Number:

Mother: Phone: Email:

Father: Phone: Email:

Does the child live with both parents? Y N If not, with whom does the child live?

Guardian: Phone: Email:

**AUTHORIZATION:** People to contact in the event of emergency if we are unable to contact parents

Name: Phone: Relationship:

Address:

Name: Phone: Relationship:

Address:

**PERSON AUTHORIZED TO PICK UP YOUR CHILD:** (copy of ID required)

Name: Phone: Relationship:

Address:

Name: Phone: Relationship:

Address:

Person who **MAY NOT** pick up your child (court order documentation is required for mother/father):

My child may be taken on field trips by public transportation Yes No

My child may have his/her pictures taken and used for Development Assessment, Curriculum,

Little Seedlings Preschool publications/social medias or yearbook Yes No

Parent’s Signature: Date:

**Little Seedlings Preschool Medical Consent for Emergency Treatment**

I hereby give permission that my child, may be given emergency treatment by qualified staff member of Little Seedlings Preschool. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. In the event that I cannot be contacted, I further consent the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed necessary or advisable by the physician to safeguard my child’s health.

Mother: Phone:

Father: Phone:

**Emergency Contact** (if parents cannot be reached):

Name: Phone:

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Child Physician: Phone:

Address:

Preferred Hospital: Phone:

Address:

My child is allergic to the following drugs or medication:

Primary Medical Insurance Coverage: Group #

Employer:

**Health Information about your Child**

Child’s Name Birthday Date:

Date of last physical exam

Findings:

Allergies Yes No

If yes, please explain

**Medications**

Please list any medications your child has been taking (prescription and non-prescription)

**Injuries and Operations**

Please list any operations or serious injuries your child has had

Has your child had RASHES/SKIN PROBLEMS? Yes/No If yes, please explain

**Illnesses**

Has your child had any other serious illness (chicken pox, Measles, Mumps, etc.) If so please

explain

Parent Signature Date