PRESCHOOL ENROLLMENT FORM

Fill in all blanks. Indicate N/A if not applicable. Please print or type information clearly

Child's Name:_____ Birthdate (mm/dd/yy):_____ Sex: M F

Nickname or preferred Name:_____ Year of enrollment: _____

PARENT/GUARDIAN INFORMATION #1

Name:_____ Relationship to child:_____

Circle Applicable Description: Married Divorced Partner Separated Single Widowed

Address:_____

City:_____ Zip:_____ Home Phone:_____

Cell Phone: _____ Email:_____

Work Phone:_____ Work Place:_____

PARENT/GUARDIAN INFORMATION #2

Name:_____ Relationship to child:_____

Circle Applicable Description: Married Divorced Partner Separated Single Widowed

Address:_____

City:_____ Zip:_____ Home Phone:_____

Cell Phone: _____ Email:_____

Work Phone:_____ Work Place:_____

If parents are not at the same address, to which parent should correspondence be addressed? _____

With whom does the child reside? _____

PRESCHOOL PROGRAM OPTIONS

I understand that I am responsible for payment based on the schedule. *Initials* _____

I agree to start my child on this date:

_____

SUMMER WEEKS ATTENDING

- ☐ Week 1: June 28-July 2
- ☐ Week 2: July 5-9
- ☐ Week 3: July 12-16
- ☐ Week 4: July 19-23
- ☐ Week 5: July 26-30
- ☐ Week 6: Aug 2-6
- ☐ Week 7: Aug 9-13
- ☐ Week 8: Aug 16-20

AUTHORIZED PICK-UP INFORMATION

Person(s) who are **AUTHORIZED TO PICK UP YOUR CHILD** if necessary, other than parent(s)/legal guardian(s)

***(Note** - In an emergency, we will try to contact you first, but if you are not able to be reached, we will contact the emergency contact(s) listed here.)*

AUTHORIZED PICK-UP PERSON #1

Name:_____ Relationship to child:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

AUTHORIZED PICK-UP PERSON #2

Name:_____ Relationship to child:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

AUTHORIZED PICK-UP PERSON #3

Name:_____ Relationship to child:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

RESTRAINING ORDER INFORMATION

Is there anyone who had a legal restraining order prohibiting or limiting contact with your child? Y N

If yes, please list his/her name below and attach the required documentation.

Name(s): _____ Relationship to child:_____

**** Please notify us if your circumstances change in any way.**

Any custody or visiting arrangements we need to be aware of?

_____

_____

_____

_____

_____

_____

_____

_____

DISASTER PREPAREDNESS EMERGENCY CONTACT:

Person(s) to be contacted in case of an emergency other than parents or legal guardian(s):

EMERGENCY CONTACT #1

Name:_____ Relationship to child:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____

EMERGENCY CONTACT #2

Name:_____ Relationship to child:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____

EMERGENCY CONTACT #3

Name:_____ Relationship to child:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____

EMERGENCY CONTACT #4 (NOT living in Bellingham*)**

Name:_____ Relationship to child:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Employer:_____ Work Phone:_____

HEALTH INFORMATION:

Our first commitment is to the children enrolled in our programs. Our ability to serve your child in the best possible manner is dependent upon you providing us with accurate health and developement information on your child.

Please be thoughtful and thorough when completing this section.

Date of last physical:_____ Dental exam:_____ Vision exam:_____

Child's Physician:_____ Phone:_____

Address:_____ Insurance:_____

Child's Dentist:_____ Phone:_____

Address:_____ Insurance:_____

A. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? **Please circle any that apply:**

Frequent Colds	Frequent Sore Throats	Frequent Ear Infections
Skin Disorders (rashes)	Heart Trouble	Convulsions
Fainting Spells	Diabetes	Asthma
Stomach Upsets	Urinary Difficulties	Frequent Diarrhea
Frequent Constipation	Febrile Seizures	Other _____

Please provide details on any items marked in the box above (A):_____

_____

_____

_____

_____

_____

_____

B. HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

ILLNESS	DATE	ILLNESS	DATE
Bronchitis		Measles (hard)	
Hepatitis		German Measles	
Chicken Pox		Mumps	
Scarlet Fever		Whoping Cough	

Please provide details on any items marked in the box above (B):_____

_____

_____

_____

_____

_____

_____

C. HAS YOUR CHILD BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? **Please circle any that apply:**

Language Delay	ADD/ADHD	Development Delays
Autism or Related Disorder	Hearing Impairment	Vision Impairment
Learning Disabilities	Mental Illness	Behavior Issues
Other _____		

Please provide details on any items marked in the box above (C): _____

Does your child have an IEP or 504 for school? Yes No
If yes, please describe special accommodations:

Does your child have an educational aide in school? Yes No

For? _____

If your child sees amy specialists (i.e. therapist, counselor, hearing/speech, etc.) please list their name and contact information:

Describe your child's overall health: _____

Present health problems (disabilities, medications, etc.): _____

Has your child ever been hospitalized? Please explain: _____

Allergies (foods, medicines, etc) & typical reactions: _____

Has your child had injuries with fractures or loss of conciousness? Please explain: _____

HEALTH INFORMATION:

Just as health and development information is important to us, in order to provide the best care for your child, relationship and other life experience information helps us to get to know your child better from the time he/she enrolls with us.

Please be thoughtful and thorough when completing this section.

Is this your child's first experience with child care? YES NO

If no, please list the previous provider's name(s), phone numbers, and the child's length of stay. There may be instances where sommunication with the previous caregiver might be helpful in working with your child.

Chld Care Provider Name	Area Code & Phone Number	Length of Enrollment

If no, please describe your child's previous group play experiences:_____

_____

_____

What do you hope your child will gain from their experience at ASA?_____

_____

Is your child adopted? YES NO If yes, does he/she know? YES NO

Are there any other details imprtant to your child's situation?_____

_____

CHILD'S SIBLINGS:

Name:_____ Birthdate:_____ Grade:_____

Name:_____ Birthdate:_____ Grade:_____

Name:_____ Birthdate:_____ Grade:_____

Other members of the household:_____

When does your child go to bed?_____ Get up?_____

Does your child sleep through the night? YES NO What is your child's bedtime routine?_____

_____

Does your child nap? YES NO If yes, approximately how long?_____

What foods does your child especially like?_____

Dislike?_____

Favorite Activities:_____

When upset, what works to comfort him/her?:_____

How does your child express anger/frustration?:_____

How do you discipline your child and who does the majority of the discipline at home?_____

_____

Does your child havve any special fears?:_____

Is there any other information about your child you want us to be aware of?_____

_____

Signature:_____ ***Date:***_____

PARENT AGREEMENT:

This is a legal document between The Firs After School Adventure Program and the parent(s)/legal guardian(s).

Parents are expected to follow all of The Firs ASA policies & procedures outlined in the Parent Handbook, which they have received and read.

Enrollment is on a continuous basis, from one school year to the next, until my child is withdrawn from the program. (There are separate enrollment forms for summer programs.) Changes to my child's schedule or complete withdrawl are subjuect to the policies outlined in the Parent Handbook and the Tuition Agreement.

The Firs ASA reserves the right to discontinue a child's enrollment. Reasons for termination include, but are not limited to, the following.

1. If a child reaches STEP THREE of the BEHAVIOR MANAGEMENT POLICY as stated in the Parent Handbook.
2. Non-payment of tuition fees by due dates. (If this happens, future enrollment may not be allowed.)
3. Physical or emotional problems, which require supervision beyond our normal teacher/child ratio. Five days notice will be given to parents/guardians before a child is dropped from our program, except in extreme cases. (Parents must specify on the enrollment form any physical, emotional, or special needs their child may have.)
4. A child may temporarily be suspended from the center as a result of behavior problems. If a child is suspended from their regular school attendance, ASA is unable to accept that child during the days of suspension.
5. Failure by the parent or child to comply with the policies and procedures established by ASA to ensure fair enrollment and billing practices.
6. Failure to notify the center in advance of non-scheduled absences.
7. False information or not fully disclosing important information regarding your child (i.e. health, development, etc.)

I grant permission to ASA to contact any individuals listed in this form (i.e. previous caregivers, physician, therapist, etc.) for additional, relevant information regarding my child. In an effort to support healthy development and academic achievement of my child, I grant permission to The Firs ASA to openly communicate with the apporpriate individuals (i.e. teacher, principal, counselor, etc.) at my child's school. ***Initials*** _____

In the interest of making sure my child is picked up only by authorized individuals and you have accurate emergency contact information, I have provided the name and phone number of at least one other person whom I have authorized to pick up my child or be contacted in case of an emergency (pages 3, 4, & 8). ***Initials*** _____

In the interest of making sure my child is accounted for, I will call the center, in advance, in the event that my child will not be in attendance, or make a note of schduled absences on the center calendar. ***Initials*** _____

Children are discouraged from bringing any toys from home. In the event that they do, I understand that ASA cannot accept responsibility for those itmes. **Toy weapons of any kind are prohibited.** ***Initials*** _____

The Firs ASA, its staff and board, make no warranty and can accept no responsibility or liability for the actions of any of its employees, agents or other related individuals outside of the agreed to hours of operation of the center or when in the case of employees or agents, they are not actively and exclusively working for The Firs ASA. ***Initials*** _____

I grant permission for ASA to provide care for my child. ***Initials*** _____

I grant permission for my child to use all of the play equipment, including the climbing wall, and to participate in all of the activities of the center. ***Initials*** _____

I grant permission for my child to ride in a Firs vehicle for the purpose of transportation. ***Initials*** _____

I grant permission for my child to be included in evaluations and pictures connected with the program. ***Initials*** _____

I grant permission for my child to be use photographs of my child for display/program purposes. ***Initials*** _____

ASA will not be responsible for anything that may happen as a result of a lack of and/or false imformation given by parent(s) or guardian(s) at the time of enrollment. ***Initials*** _____

All of the information I have provided is true and correct to the best of my knowledge. ***Initials*** _____

Signature: _____ ***Date:*** _____

TUITION AGREEMENT:

Date that a copy of this agreement was given to Parent/Guardian:_____Initials:_____

This is a legal document between The Firs After School Adventure Program and the parent(s)/legal guardian(s).

Please Initial

Tuition is due by the 10th of each month. Regular monthly tuition does not include holidays. **No Credit** will be given for hours signed up for but not used. A monthly billing, complete with envelope, is placed in your file folder, located in the ADventure Center, or emailed to you. (*If paying by check, please write your child's name in the "memo" of your check.*) _____

I prefer to receive my monthly statement via: ○ **Email** ○ **Paper statement**

Payments are recorded within 3 business days of the date the payment is received. If the monthly payment is not received by the 15th of the month, a $25 late fee **may be** charged to my account. If the balance is not paid in full by the end of the month, enrollment may be suspended. _____

All tuition payments are to be made out to The Firs ASA, mailed or placed in the tuition box in the sign-in area. Statements will be placed in the Family File or emailed. If I do not receive my monthly statement it is my responsibility to call or ask the ASA Director or Registration Office for the correct amount due. _____

If a child is picked up after the time his/her program is scheduled to end, the late pick-up fee is $15 for the first 15 minutes and $1 per minute for every minute thereafter. This payment must be made at the time of pick-up or it will be added to my child's care account. Failure to pay these charges may result in termination or enrollment. _____

In the event I fail to notify ASA that my child will not be attending on any scheduled day, a $10 fee for failing to notify ASA **may be** charged to my account. In order to avoid this fee, I will need to contact the center at least 1 hour before my child is expected to arrive by calling **820-2031**. You may leave a message. Excessive failure to notify may result in suspension or termination of enrollment. _____

A minimum of 2 weeks' written notifiaction must be given for withdrawl from the program. Tuition will accrue for 2 weeks from the date written notice is received. If less that 2 weeks writeen notice is given, tuition will accrue for 2 weeks after my child's last date of attendance and my deposit on file will be forfeited. _____

I understand and accept that there is no credit for absences and days that the Program is closed; the registration fee is non-refundable and is charged annually. _____

This contract is effectice for the duration of my child's enrollment in ASA. Changes to my child's schedule or complete withdrawl from the program are subject to the policies outlined in the Parent Handbook and the Tuition Agreement. _____

All fees and policies are subject to change annually. _____

I have read and accept the conditions outlined in the Parent Handbook, the Enrollment Packet, the Parent Agreement, and the Tuition Agreement. _____

Signature:_____ ***Date:***_____

HEALTH & WELL-BEING AGREEMENT:

Date that a copy of this agreement was given to Parent/Guardian:_____Initials:_____

Per Washington state child care licensing and public health requirements, the following is available for parents to review at any time. These documents are posted in the parent area and copies are available. Please take time to read and understand these documents and initial next to each item that you have reviewed or understand that they are available for review.

1. Health Policy: ASA policy and procedures relating to staff and child health practices, communicable disease exposure and reporting, medication and first-aid management, and other health-related topics. ***Initials*** _____
2. Pesticide Poicy: ASA policy adheres to public health standards. ***Initials*** _____
3. Disaster Preparedness Policy: ASA policy works in partnership with the schools that it serves. This covers policy for major natural disaster preparedness, staff responsibility and disaster supply management. ***Initials*** _____

Signature:_____ ***Date:***_____

FIELD TRIP PERMISSION:

Date that a copy of this agreement was given to Parent/Guardian:_____Initials:_____

Throughout the year, we take field trips to local parks, beaches, woods, or public places, and extended Firs property. All trips will be adequately staffed to provide the utmost safety for your child, while enjoying an enriching visit to a nearby place. Parents will be notified of the trip in advnace, with the time of departure and arrival back at the center, unless it is a “walking” field trip to the greater Firs property. This information will be posted on the door of the center. Parents will be allowed to pick up their child from a local field trip location, provided they have authorization and have picked up their child before (staff will recognize you) and sign out their child at the center in the sign-in/out book prior to pick up.

I give permission for my child to attend field trips with The Firs ASA throughout the year.

In the event that field trips are scheduled that require a border crossing into Canada, I am aware that my child will need to have their birth certificate or passport and/or proof of guardianship, along with a signed permission slip (provided in advance by ASA).

Signature:_____ ***Date:***_____

CONSENT FOR EMERGENCY TREATMENT:

Date that a copy of this agreement was given to Parent/Guardian:_____Initials:_____

As the parent or legal guardian, i hereby give consent to THe Firs ASA that my child,_____, may be given emergency treatment, including First Aid?CPR by a qualified staff member of ASA or Medic 1. I also give permission for my child to be transported by an aid car, ambulance or qualified staff car, to the nearest medical treatment center or hospital, if necessary.

In the event that I cannot be contacted, I further consent to the medical, dental, surgical and hospital care, treatment and procedures to be performed for my child by a lisenced physician (M.D.), dentist (D.D.S.), or hospital, when deemed immediately necessary or advisable by the physician to safeguard the life, limb or well-being of my child.

It is understood that a conscientious effort will be made to notify me or other persons listed on this form before such action is taken. The expense of this service will be accpeted by me.

Child’s physician:_____ Phone:_____

Preferred Hospital:_____ Phone:_____

Insurance:_____ Policy Number:_____

Allergy (drug/other) Reactions:_____

_____

Signature:_____ ***Date:***_____

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY)**:**	**Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil®9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 December 2016