



5900 Chippewa Blvd., Houston, Texas 77086  
 Phone 281-445-9574  
 Fax 281-977-3390  
 Email: mips@mipstx.org  
 Website: maryimmpreschool.org

## ENROLLMENT FORM

*Please complete entire Enrollment form, do not leave blanks. PRINT CLEARLY!*

<b>Child's Full Name</b> _____ Date of Birth _____ Child's Home Address _____ City, State, Zip _____ Child's Home Phone Number _____ Date of Admission _____	
<b>Mother's Full Name</b> _____ Cell Phone Number _____ Work Phone Number _____ Email Address _____	<b>Father's Full Name</b> _____ Cell Phone Number _____ Work Phone Number _____ Email Address _____
Parent's name & address (if different from child's address): _____ _____	
Is there a custody order on file with the State of Texas? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING If <b><u>YES</u></b> , a current copy of your court order <b>MUST</b> be attached.	
<b>Emergency Contact</b> if parents cannot be reached:      Relationship _____ Name _____ Address _____ Phone _____	
<b>Authorization to pick up:</b> Name/Phone _____ Name/Phone _____ Name/Phone _____ Name/Phone _____	

<b>Authorized for Emergency Medical Attention</b> In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:	
Name of Physician _____ Address _____ Phone _____	Emergency Medical Care Facility _____ Address _____ Phone _____
<input type="checkbox"/> I give consent for the facility to secure any and all necessary emergency medical care for my child.	

<b>Special Needs</b> List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during that past 12 months, and medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:  Does your child have diagnosed food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No      Plan Submitted on _____  <input type="checkbox"/> I give consent for the facility to post my child's allergies in the classroom.
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**Consent** (check all that apply)

**Transportation**

I consent for my child to be transported and supervised by the operations employees for:

- for emergency care       field trips

**Field Trips**

I (give / do not give) consent for my child to participate in field trips.

- give       Do not give

**Water Activities**

I give consent for my child to participate in water activities:

- Sprinkler Play       Splashing/Wading Pools       Water Table Play       Aquatic playgrounds

**Meals**

- I understand that breakfast, lunch, and an afternoon snack will be served.

**Operational Policies**

- I acknowledge receive the facility's written **operational policies** including those for discipline and guidance.

**Sunscreen/insect repellent**

I (give / do not give) consent for sunscreen/insect repellent to be applied to my child as needed.

- give       Do not give

**Photo Release**

- From time to time our facility may take photographs for educational use. I give consent for the facility to take photographs of my child.

**Attendance**

My child will normally be in attendance the following days and times:

Monday:      from \_\_\_\_\_ to \_\_\_\_\_

Tuesday:      from \_\_\_\_\_ to \_\_\_\_\_

Wednesday: from \_\_\_\_\_ to \_\_\_\_\_

Thursday:      from \_\_\_\_\_ to \_\_\_\_\_

Friday:      from \_\_\_\_\_ to \_\_\_\_\_

**Health Statement**

My child has been examined within the past year by a health care professional and is able to participate in the preschool program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the preschool operation.

Health Care Professional Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
**Parent or Legal Guardian Signature**

\_\_\_\_\_  
**Date**



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## Physician's Statement

*Please complete entire Enrollment form, do not leave blanks. PRINT CLEARLY!*

**Name of Child** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I have examined the above child within the past year and find that he/she is able to take part in the preschool program.

**Health Care Professional Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health Care Professional Signature \_\_\_\_\_ Date \_\_\_\_\_

Vaccine Information	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mo	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae type B											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningocccal											

**Physician or Public Health Personnel Verification**

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Varicella** (chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) \_\_\_\_\_ and does not need varicella vaccine.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Requirements for Exclusion**

I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Food Allergy Emergency Plan

This plan must be signed and dated by your child's Health Care Professional.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The child is allergic to these food: \_\_\_\_\_

Possible symptoms for **each** known food allergy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific steps to take if the child has an allergic reaction to **each** known food allergy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*By signing below, the parent or guardian of this child gives Mary Immaculate Preschool permission to post the child's food allergy in the food serving and food preparation areas.*

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For licensed center use:

\_\_\_\_\_ Food Allergy Emergency Plan has been posted in the classroom and food service area

\_\_\_\_\_ Food Allergy Emergency Plan has been posted in the food preparation area

\_\_\_\_\_ Food Allergy Emergency Plan has been included in your emergency evacuation binder

\_\_\_\_\_ Food Allergy Emergency Plan has been included in your field trip and transportation binder



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## Authorization For Emergency Medical Care

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give permission for Mary Immaculate Preschool and its staff to take my child:

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Doctor:**

Name of Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Hospital:**

Name of Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list any known allergies or illness that would conflict with emergency care or treatment:

\_\_\_\_\_  
*Parent or Legal Guardian Signature*

\_\_\_\_\_  
*Date*

*(Please attach a current photo of your child.)*



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## Tuition Agreement

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parents Name: \_\_\_\_\_

Registration fee: \$ \_\_\_\_\_ Annually Supply fee: \$ \_\_\_\_\_ Monthly Tuition amount: \$ \_\_\_\_\_

Payment for my Child's is due on first week of the Month. A full tuition is charged for complete as well as partial attendance. Tuition is considered "overdue" by the 10<sup>th</sup> of the month; after the 10<sup>th</sup> there will be a **10% Late Fee** assessed.

Our program is open Monday through Friday from 7:30 am to 5:00 pm. Mary Immaculate Preschool is only licensed by the Texas Department of Family and Protective Services to care for children during these specified times. If I am late picking up my child, a **\$1 a minute** late penalty will be charged to my account.

Mary Immaculate Preschool chooses not to get involved in custody disputes. In the event a court order is on file, Mary Immaculate Preschool will not acknowledge which party is responsible for payment of tuition fees. These arrangements must be coordinated between the two parents. Late fees and withdrawal guidelines will still apply regardless of which parent is responsible for tuition fees.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Signature

\_\_\_\_\_  
Date



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## Parent Handbook Acknowledgement

I, \_\_\_\_\_, (Parent/Guardian Name) have been given a copy of the Mary Immaculate Preschool Parent Handbook, I have read the policies outlined, and given the opportunity to ask questions regarding Mary Immaculate Preschool policies. I understand the policies and will agree to follow the policies outlined in the Mary Immaculate Preschool Parent Handbook. I understand that Mary Immaculate Preschool has the right to terminate care at any time if the parent policies are not followed.

Child(ren)'s Name(s): \_\_\_\_\_

Parent/ Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_