Registration Documents for New Enrollees

Instructions:

1. Complete all documents clearly and completely. PLEASE PRINT!

2. Your child may not start school until we have ALL these documents.

3. Please make sure the medical form is signed by your physician or a registered nurse. You may contact the Douglas County Health Nurse at 782-9038 to update your child's immunization record and/or health statement.

4. Don't forget your child's immunization records.

5. A separate package and registration fee is necessary for each child.

6. The attached Policies and Procedures Manual has information vital to your child's attendance. BE SURE TO READ THE ENTIRE MANUAL! You are accountable for the rules and regulations the manual contains.

7. If you have any questions about any of the items in this Registration Package, or the Policies and Procedures Manual, please see the Director or the Secretary.

Registration Form #1

Please print and include your registration fee of $40.00 with this package.

Student's Name: _____ Nickname: _____
Date of Birth: _____ Sex: _____
Mailing Address: _____
Physical Address: _____

In case of an emergency while my child is attending Saint Gall Catholic Pre-School, contact: (please circle) **Mother** **Father** **Either**

Mother can be reached at _____ *during* _____
or _____ *during* _____
Father can be reached at _____ *during* _____
or _____ *during* _____
If neither parent can be reached in an emergency, the pre-school will contact these people:
Name _____ *can be reached at* _____
Relationship to child _____
Name _____ *can be reached at* _____
Relationship to child _____

Doctor or Clinic to be contacted in case of an emergency:
Doctor _____ Address _____
Phone _____ Clinic _____

Allergies: _____
Known medical conditions: _____

Office Use Only:

Date Registered: _____ Amount Paid: _____

Check #: _____ First Day: _____
Forms #1___1A___2___3___4___5___6___7___8___9___
Date Closed: _____ Balance Owed: _____
Reason: _____

Registration Form #1-A

Please Print!
List the people who are authorized to pick up your child, including yourself.
Update this form if the names change.

Effective Date: _____

Child's Name: _____

#1 Name: _____
Relationship to child: _____

#2 Name: _____
Relationship to child: _____

#3 Name: _____
Relationship to child: _____

#4 Name: _____
Relationship to child: _____

#5 Name: _____
Relationship to child: _____

#6 Name: _____
Relationship to child: _____

Signature of Parent/Guardian: _____

Family History Form #2

The purpose of this form is to enable us to know your child and his/her needs so we may do the best job possible. All information is kept confidential.

Child's Name: _____

Family Name if different from Child's Name: _____

List all of the children in the family in order of age:

1. _____ Age _____ 2. _____ Age _____
3. _____ Age _____ 4. _____ Age _____
5. _____ Age _____ 6. _____ Age _____
7. _____ Age _____ 8. _____ Age _____

Have parents been divorced or separated? _____

Is either parent deceased? _____

Any additional information you feel would help us to avert any problems, and in turn, make this an exceptional pre-school experience for your child, i.e., this is the first time for the child to be in a class setting, child is very shy, child usually has a mid-morning nap, etc.

_____

_____

_____

_____

_____

_____

_____

Health History Information Form #3

Child's Name: _____ Date of Birth: _____
Age: _____ Sex: _____

Please check if any of the following apply and explain fully below: (Use a separate sheet of paper if necessary.)

_____ Diabetes	_____ Speech	_____ Heart Problems
_____ Asthma	_____ Allergies	_____ Emotional
_____ Hearing	_____ Epilepsy	_____ Behavioral

Other, please explain: _____
_____

Status of Above Child's Health: _____

CARE INSTRUCTIONS FOR SPECIFIC HEALTH PROBLEMS (BE VERY SPECIFIC)

_____

_____

_____

Does your child have frequent? (Please check the following)

_____ Colds	_____ Tonsilitis	_____ Earaches
_____ Sore Throat	_____ Stomach Aches	_____ Bloody Nose
_____ High Fever	_____ Low Grade Fever	

Explain: _____
_____

DOES YOUR CHILD TAKE MEDICATION ON A REGULAR BASIS?

Explain: _____
Physician: _____ Phone: _____

Saint Gall Catholic Pre-School is in no way financially responsible for any medical care and/or emergency transportation supplied to your child(ren) in the case of an emergency. (See *Emergency Procedure and Release of Liability Affidavit* for further details.)

Date: _____ Signature: _____

Nevada Record of Immunization Form #4

This information is required by The Nevada State Health Division. Your child will not be admitted without these records.

Please provide us with a current and legible copy of your child's record. His/Her name must appear on the record.

Emergency Procedure and Release of Liability Affidavit Form #5

I, true parent or legal guardian of (child's name) _____

Do hereby grant permission to the staff of Saint Gall Catholic Pre-School to administer first-aid and emergency treatment in the event of an accident or emergency. It is understood that said parent shall be reached as soon as possible in case of accident or emergency.

DOCTOR'S NAME: _____

ADDRESS: _____

PHONE: _____

In the event that neither physician nor parent or legal guardian can be reached, Saint Gall Catholic Pre-School may contact any Nevada State licensed practicing physician. I agree to pay for any costs and medical bills incurred. I understand that Saint Gall Catholic Pre-School is not responsible for any medical care and/or emergency transportation supplied to my child in the case of an emergency.

It is understood that Saint Gall Catholic Pre-School and staff are released from liability for any accidents or emergencies.

Date: _____ Signature: _____
(Parent or Legal Guardian)

Registration Form #6
Parent/Guardian Financial Agreement

I agree to enroll my child (name) _____
at Saint Gall Catholic Pre-school. I have received and read a copy of the Policies and Procedures of the Saint Gall Catholic Pre-School. I agree to adhere to said policies and procedures. Class for my child will normally begin at 8:30 am and will end at 12:30 pm on the following weekdays: _____
The charge for the classes are $_____ per week.

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

- Payments are due monthly or weekly, in advance. Saint Gall Catholic Pre-School operates solely from tuition and donations. This program time is being reserved for my child. My child's tuition is due whether or not my child is in attendance that week/day. Because this is an annual tuition, sick days are not discounted.

- Late pick-up fee is $1.00 per minute beginning at 12:45 pm.

- Registration fee and all tuitions are non-refundable. There is a $25 service charge on all returned checks.

Late fees of 2% may be applied to all accounts past due 10 days or more.

In the event of an emergency, I understand that Saint Gall Catholic Pre-School is not financially responsible for any emergency vehicle transportation costs or for any medical care or costs incurred by my child/children as a result of Saint Gall Catholic Pre-School initiating this care.

Date: _____ Father's Signature: _____

Date: _____ Mother's Signature: _____

Field Trip Permit Form #7
Authorization for Escort

I understand that during the year my child, _____ may take pare in field trips and educational excursions either by private car or on foot. My child will be chaperoned by a responsible adult at all times while away form school.

Notice of field trips will be posted in advance in the weekly calendar and on the parent bulletin board.

Should any accident or illness occur while my child is away from the school on the aforementioned trip, I shall not hold responsible the child's teacher, members of the staff of Saint Gall Catholic Pre-school nor any participating adult.

Date: _____ Signature: _____
(Parent or Legal Guardian)

Permission to Release Information and Progress Report Consent Form #8

I understand that during the time my child, _____ is in school at Saint Gall Catholic Pre-School, the Director may be asked for information regarding my child. I hereby give permission to release information to official persons only who adequately identify themselves, such as school, health care personnel, welfare or other governmental officials.
Date: _____ Signature: _____
(Parent or Legal Guardian)

I do not give permission to release information about my child as set forth in the aforementioned statement.
Date: _____ Signature: _____
(Parent or Legal Guardian)

I allow the teacher to evaluate my child's progress

Date: _____ Signature: _____
(Parent or Legal Guardian)

☐ Check for Allergies

Emergency Card #9
Saint Gall Catholic Pre-School

D.O.B. ____/____/____

Child's Name: _____
Last First Middle

Address: _____

Mother's Name: _____ Home Phone: _____ Work: _____
Father's Name: _____ Home Phone: _____ Work: _____
Mother's Cell #: _____ Father's Cell #: _____
#1 Alternate Contact: _____ Phone #: _____
#2 Alternate Contact: _____ Phone #: _____
Physician: _____ Phone #: _____
Hospital Preferred: _____ Medical Insurance: _____

I, _____, give consent for my child, _____, to be treated for medical or surgical emergencies by any licensed physician or hospital in the event that I cannot be located.

Date: _____ Signature: _____
(Parent or Legal Guardian)

☐ Check for Allergies

Emergency Card #9
Saint Gall Catholic Pre-School

D.O.B. ____/____/____

Child's Name: _____
Last First Middle

Address: _____

Mother's Name: _____ Home Phone: _____ Work: _____
Father's Name: _____ Home Phone: _____ Work: _____
Mother's Cell #: _____ Father's Cell #: _____
#1 Alternate Contact: _____ Phone #: _____
#2 Alternate Contact: _____ Phone #: _____
Physician: _____ Phone #: _____
Hospital Preferred: _____ Medical Insurance: _____

I, _____, give consent for my child, _____, to be treated for medical or surgical emergencies by any licensed physician or hospital in the event that I cannot be located.

Date: _____ Signature: _____
(Parent or Legal Guardian)

Allergies (and usual symptoms) _____

_____

_____

Date of last Tetanus Shot: _____

Has your child ever had a seizure? _____

Under what conditions did the seizure occur? _____

_____

_____

_____

Please list any other health problems such as an unusual tendency to bleeding, fainting, etc.

_____

_____

_____

Date: _____ Signature: _____

Allergies (and usual symptoms) _____

_____

_____

Date of last Tetanus Shot: _____

Has your child ever had a seizure? _____

Under what conditions did the seizure occur? _____

_____

_____

_____

Please list any other health problems such as an unusual tendency to bleeding, fainting, etc.

_____

_____

_____

Date: _____ Signature: _____