

GIANT STEPS EARLY LEARNING SCHOOL

Enrollment form

Child's Name		Date of Birth	Child's Home Telephone Number	
Child's Street Address			Child's Zip Code	
Date of Admission	Date of Withdraw	Hours and Days child will be in care full time (M-F) part time (T-TH) (M-W-F)		Extended Care Days per a week 0 1 2 3 4 5
Parent's or Guardian's Name		Address (if different from child's address)		
List telephone numbers where parent/guardian may be reached:	Mother's Telephone Number	Father's Telephone Number	Guardian's Telephone Number	
Mother's Place of Employment	Father's Place of Employment		Child Resides with: __ 2 parents __ mother __ father __ guardian __ grandparents	
Household Income:	__ \$20,000-35,000	__ \$35,000-50,000	__ \$50,000-75,000	Number of children ages 0 - 5 years
	__ \$75,000-90,000	__ \$90,000-125,000	__ \$125,000 - Above	
Give name of person to call in case of an emergency if parents/guardian cannot be reached: Name		Telephone Number/ Address		Relationship
I hereby authorize Giant Steps Early Learning School to allow my child to leave the facility ONLY with the following persons				
Name and Phone Number		Name and Phone Number		Name and Phone Number

WATER ACTIVITIES: I hereby give do not give - my consent for my child to participate in water activities:
 splashing pools water slides sprinklers

ARE YOU A NEW FAMILY TO GIANT STEPS? _____ If no, how many children have attended Giant Steps? _____

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medications prescribed for long-term continuous use, and any other information which staff should be aware of:

In the event that I CANNOT be reached to make arrangements for medical attention, I authorize Jennifer Dhaemers, facility director, or person in charge to seek medical treatment.

Name of Physician: _____ Address/Phone: _____

Name of Hospital: _____ Address/Phone: _____

I give consent for Giant Steps to secure any and all necessary emergency medical care for my child _____

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Health Requirements

Name of Child: _____		Date of Birth: _____			
IMM	Date / Dose 1	Date / Dose 2	Date / Dose 3	Date / Dose 4	Date / Dose 5
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola / Serampion					
MUMPS	Please attach a copy of shot records.				
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)					
Varicella (see below)					
<p>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 disease (chickenpox) on or about (date) _____ and does not need varicell vaccine.</p> <p>Parent's Signature _____ Date: _____</p>					

Signature - Physician or Health Personnel and Date

Signature - Staff Making Handwritten Copy and Date

ADMISSION REQUIREMENTS: One of the following must be presented when your child (under the age of 5 years) is admitted to Giant Steps PRIOR TO START DATE!
Check to indicate the option you select:

_____ **HEALTH CARE PROFESSIONAL STATEMENT:** I have examined the above named child within the past year and find that he / she is physically able to take part in Giant Steps.

Physician's Signature

Date

_____ A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if not referral for further diagnosis and treatment is indicated.

_____ A SIGNED AND DATED statement from a health service or clinic.

_____ Medical diagnosis and treatment with the tenets and practices of a recognized religious organization, which I adhere to or am a member of ; I have attached a signed and dated affidavit. I understand the affidavit is valid for 2 years.

Signature - Parent of Legal Guardian and Date

HEARING	DATE	SIGNATURE		PASS	FAIL
Hz	1000	2000	4000	_____	_____
R					
L					
VISION	DATE	SIGNATURE		PASS	FAIL
	R/20 _____		L/20 _____	_____	_____