

Date _____

Registration Fee _____

**South Gate Children's Day Out
Registration Form
2018 -2019**

Child's Name _____ Nickname _____

Birthday (month/day/year) _____ Enrollment Date _____

Parent/Guardian information

Mother's Name _____

Father's Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Cell # _____ Home _____

Cell # _____ Home _____

Employer _____

Employer _____

Position _____

Position _____

Address _____

Address _____

Work Phone _____

Work Phone _____

Email _____

Email _____

Child lives with: ___ Mother ___ Father ___ Both ___ other _____

Siblings: Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

I'm enrolling my child for the following sessions: (You may choose up to 3 days)

Drop off is between 8:45 to 9:00 a.m.

18 months to 3 year olds

Tuition: \$11.90 for half day session

___ Monday 9:00 – 11:30 a.m.

___ Tuesday 9:00 – 11:30 a.m.

___ Wednesday 9:00 – 11:30 a.m.

___ Thursday 9:00 – 11:30 a.m.

___ Friday 9:00 – 11:30 a.m.

6 Weeks to 18 Months

Tuition: \$12.90 for half day session

___ Tuesday 9:00 – 11:30 a.m.

___ Wednesday 9:00 – 11:30 a.m.

___ Thursday 9:00 – 11:30 a.m.

Local Emergency Contacts (other than parents. Must include 2)

Name _____

Name _____

Address _____

Address _____

Cell # _____ Home # _____

Cell # _____ Home # _____

Relationship to Child _____

Relationship to Child _____

Persons permitted to pick up your child

Persons listed will need to show a valid driver's license before child will be released.

Name _____

Name _____

Cell # _____ Home # _____

Cell # _____ Home # _____

Relationship to Child _____

Relationship to Child _____

Neighborhood Walks

I hereby give South Gate Preschool permission to take my child on a walk around the preschool Neighborhood.

Signature of Parent/Guardian

Date

Consent to Contact Physician in an Emergency

In the event that I cannot be reached to make arrangements, I hereby give my consent to South Gate Preschool to Contact:

Name of Physician _____

Phone

Address

City

zip

And if necessary, call emergency personal. I prefer my child be taking to _____

Hospital

Signature of Parent/Guardian

Date
Updated 1/17 (CDO)

Child's Medical Information

Current Health status or any health problems caregiver should know? _____

Special Diets

Does your child require a modified diet or have an intolerance to food _____ No _____ Yes

If yes, please explain/details: _____

Allergies _____ No _____ Yes If yes, please explain/details:

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Comments _____

I understand that if my child is allergic to anything or has an intolerance to food, my child's information will be posted in his/her classroom. This posting are informational and intended to provide safety for my child.

Special concerns: (Glasses, Hearing Aids, Speech) _____

Any activities Child should NOT engage in: _____

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian _____
Date

Immunization Records

In order for children to attend South Gate Preschool and Children's Day Out we require that ALL children are current with their immunizations. The Lancaster County Health Department require us to maintain current documentation of each child's immunization records. We **MUST** have a copy of your child's immunizations before they begin Preschool or CDO.

<u>First Name:</u>		<u>Last Name:</u>		<u>Date of Birth:</u>		
PCV 1 / /	DTaP 1 / /	IPV 1 / /	HIB 1 / /	HEP-B 1 / /	MMR 1 / /	VAR 1 / /
PCV 2 / /	DTaP 2 / /	IPV 2 / /	HIB 2 / /	HEP-B 2 / /	MMR 2 / /	VAR 2 / /
PCV 3 / /	DTaP 3 / /	IPV 3 / /	HIB 3 / /	HEP-B 3 / /		
PCV 4 / /	DTaP 4 / /	IPV 4 / /	HIB 4 / /	***REFUSAL:	() Copy of Immunization Refusal Form <u>must</u> be included with this report.	
	DTaP 5 / /			***VARICELLA:	() Copy of Varicella Disease Verification Form <u>must</u> be included with this report.	

PCV – Includes PCV7 or 13, (Pevnar) and PPV23

DTaP – Includes DtaP and DTP (Diphtheria, Tetanus, Pertussis)

DT (Diphtheria, Tetanus – Pediatric)

Td (Tetanus, Diphtheria – Adult)

IPV – Includes OPV (Oral Polio Vaccine)

IPV (injectable Polio Vaccine)

HIB – Haemophilus Influenzae Type B

Hep B – Hepatitis B

MMR – Measles, Mumps, Rubella

VAR – Varicella VZV

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

Date