



First Friends Enrollment Form

Katie Burgess, Director
~DUE: MARCH 30, 2024~

Child's Name _____

Sex _____ Date of Birth _____ Age as of Sept 1, 2024 _____

Home Address _____ City _____ State _____ Zip _____

Email for school use _____ Hm Phone _____

Mother's Name _____ Cell number _____

Father's Name _____ Cell number _____

Father's Work Phone _____ Mother's Work Phone _____

What church does your family attend? _____

Has your child been professionally evaluated for any services? If so, what? _____

EMERGENCY CONTACT PERSON (AUTHORIZED TO PICK UP CHILD): In the event that either parent cannot be contacted or cannot pick up their child, these persons can act of the parent's behalf and are authorized to pick up at First Friends. **Please include at least 2 contacts. All information must be included.**

Name	Address, City, State & Zip	Phone Number
1.		
2.		
3.		
4.		

Please initial the following:

First Friends "Parent Handbook" & "Discipline & Guidance" policy are both located on our website: www.firstfriendspreschool.org, under the registration tab. Click on "Parent Policies".

1. _____ RECEIPT/UNDERSTANDING OF PARENT/STUDENT HANDBOOK I acknowledge receipt/understanding of the "Parent Handbook" & will adhere to its policies
2. _____ RECEIPT OF DISCIPLINE & GUIDANCE POLICY I acknowledge receipt of the "Discipline & Guidance" policy
3. _____ I give consent for photographs and/or video to be taken of my child while at First Friends. I understand that some photographs will be submitted to the Prosper Press, or could be put on the First Friends website or First Friends Facebook page.

Signature of Parent _____ Date _____

For office use only:

Date of Admission _____ Date of Withdrawal _____



HEALTH ADMISSION REQUIREMENTS

FBC Prosper
Katie Burgess, Director

STUDENTS NAME: _____

DOB: _____

HEALTH STATEMENT: (Check One)

- Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.

Health Professional's Signature

Date

OR

- A signed and dated copy of a health care professional's statement is attached.

OR

- Medical diagnosis and treatment conflict with the tenants and practices of a recognized organization which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

IMMUNIZATION REQUIREMENTS: (Check One)

- I have attached a copy of my child's current physician immunization record.
My child had Varicella disease (chickenpox) No Yes, Date _____

OR

- I am excluding my child from the immunization requirements for reason of consciences, including a religious belief. I have attached an official affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years. *For additional information regarding immunizations, contact the Department of State Health Services at: http://www.dshs.state.tx.us/immuize/school_info.htm*

HEARING & VISION REQUIREMENT FOR 4 & 5 YEAR OLDS: (Check One)

- I have attached a copy of my child's Hearing and Vision Results
Hearing Results must include Hearing frequencies (1000, 2000, & 4000 Hertz)
Vision must include distance acuity (20/20, 20/30, etc)

OR

- I will have my child receive their testing in the fall at First Friends for approximately \$20.00.

OR

- Hearing & Vision Requirements are not applicable to my child because he/she is under 4 years of age.

Signature of Parent: _____

Date: _____



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Name of Child: _____ DOB: _____

MEDICAL TREATMENT AUTHORIZATION

I, _____, give First Friends permission to obtain emergency medical treatment for my child. If the physician listed below cannot be reached, permission is granted for another licensed physician to be called.

Child's Physician _____ Physician's Phone _____

Address _____

Hospital Preference _____ Address & Phone _____

Medical Plan _____ Group Number _____ Policy Number _____

Allergies & Medical Needs

Allergies: _____

(If none, please write NONE above)

List any special needs (if none please write NONE): _____

Signature of Parent: _____

Date: _____

Allergy Emergency Plan

First Friends Preschool 2024-2025

Child's Name: _____

Date of Birth: _____

Parents' Name: _____

Parent's Contact Phone Number: _____

Allergies & Medical Needs:

----- My child has **not** been diagnosed by a health-care professional.

----- My child **has** been diagnosed by a health-care professional.

If you checked "yes" to your child being diagnosed by a health-care professional, then please contact your physician and have them submit to First Friends a food allergy emergency plan that is specific to your child and includes:

1. a list of each food the child is allergic to;
2. possible symptoms if exposed to a food on the list; and
3. the steps to take if the child has an allergic reaction.
4. the physician's signature and date
5. and the parent's signature and date

Students Name: _____ Date: _____

ADDENDUM TO 2023-24 Registration Paperwork

Water activities:

I give consent for my child to participate in the following water activities (Check all that apply).

- Water table play sprinkler play splashing/wading pools swimming pools
 aquatic playgrounds

Is your child able to swim without assistance?

- No Yes

If no, what type of assistance is needed?

Child's Special Care Needs (check all that apply):

- NONE Limitaions/restrictions on child's activities
 Existing illness Adaptive equipment (include instructions below)
 Previous serious illness Sympmtoms or Indications of complications
 Injuries/Hospitalizations (past 12 months) Medications prescribed for continuous, long-term use
 Other: _____ Environmental Allergies

Explain any needs selected above: _____

Parents Signature: _____ Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).