



1407 Victory Lane, Alvin, TX 77511

281-756-0990

## REGISTRATION FORM

DATE OF ADMISSION \_\_\_\_\_

### PERSONAL INFORMATION

CHILD'S NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

CHILD'S STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOURS AND DAYS CHILD WILL BE IN CARE \_\_\_\_\_

MOTHER AND FATHER *or* GUARDIANS NAME \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

MAILING ADDRESS  
(If different from above) \_\_\_\_\_

MOTHER'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

FATHER'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

MOTHER'S CELL \_\_\_\_\_ FATHER'S CELL \_\_\_\_\_

MOTHER'S TDL#: \_\_\_\_\_ FATHER'S TDL#: \_\_\_\_\_

How did you hear about us? (If parent referral, please write name below, so we may show our appreciation.)

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

## EMERGENCY INFORMATION

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_

FATHER'S PHONE # \_\_\_\_\_ MOTHER'S PHONE # \_\_\_\_\_

IN CASE OF EMERGENCY AND PARENTS CANNOT BE REACHED, GIVE NAME OF PERSON TO BE CONTACTED:

NAME \_\_\_\_\_

PHONE NUMBERS \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

### AUTHORIZATION FOR MEDICAL ATTENTION:

IN THE EVENT THAT I CANNOT BE REACHED TO MAKE ARRANGEMENT FOR EMERGENCY MEDIAL ATTENTION, I AUTHORIZE THE FACILITY OR PERSON IN CHARGE TO TAKE MY CHILD TO:

NAME OF LICENSED PHYSICIAN: \_\_\_\_\_

COMPLETE ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

OR:

NAME OF HOSPITAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

I GIVE MY CONSENT FOR NECESSARY EMERGENCY TREATMENT WHEN MY CHILD IS IN CARE AT THIS PHYSICIAN'S OFFICE AND/OR HOSPITAL/CLINIC.

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

\_\_\_\_\_  
Date

LIST ANY SPECIAL PROBLEMS YOUR CHILD MAY HAVE, SUCH AS ALLERGIES, EXSISTING ILLNESS, PREVIOUS SERIOUS ILLNESS, INJURIES DURING LAST 12 MONTHS, MEDICATIONS FOR LONG TERM CONTINUOUS USE, AND ANY OTHER INFORMATION STAFF SHOULD BE AWARE OF:

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

**ADMISSION REQUIREMENTS**

**CHILD'S NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**ONE OF THE FOLLOWING MUST BE PRESENTED WHEN YOUR PRE-SCHOOLAGE OR INFANT CHILD IS ADMITTED TO THE DAY CARE FACILITY.**

<p><b>1. Doctor's Statement:</b> I have examined the above named child within the past year and find that he/she is physically able to participate in a day care program.</p>	
<p>_____</p> <p>Physician Signature</p>	<p>_____</p> <p>Date</p>

- 2. A copy of the medical screening form from the early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. (This is acceptable if no further diagnosis and treatment is indicated).
- 3. A form or written statement from a health service or clinic.

YOUR DOCTOR'S OFFICE CAN FAX US A STATEMENT REGARDING THE ABOVE TO:  
281-331-2653

**IF YOU DO NOT HAVE ANY OF THE ABOVE, THE FOLLOWING WILL BE ACCEPTABLE FOR NOW WITH THE ABOVE BEING PROVIDED WITHIN THE NEXT WEEK:**

**PARENT'S STATEMENT:** My child has been examined within the past year by a licensed physician and is able to participate in the day care program.  
**Name and address of physician or screening site:**

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

\_\_\_\_\_  
Parent signature

**NOTE: YOU MAY SUBMIT A MACHINE COPY OF YOUR IMMUNIZATION RECORD SIGNED OR STAMPED BY A PHYSICIAN OR HEALTH PERSONNEL**

**SCHOOL AGE CHILDREN:**  
MY CHILD'S IMMUNIZATION/HEALTH RECORDS ARE ON FILE AT THE SCHOOL AND ALL IMMUNIZATIONS AND HEALTH INFORMATION IS CURRENT.

**MY CHILD ATTENDS:**

Name of school and address	Phone Number
_____	_____
_____	

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**RELEASE INFORMATION:**

I HEREBY AUTHORIZE PRECIOUS STONES PRESCHOOL TO ALLOW MY CHILD TO LEAVE THE DAY CARE FACILITY ONLY WITH THE FOLLOWING PERSONS:

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_

**TRANSPORTATION:** I UNDERSTAND THAT MY CONSENT *MAY BE REQUESTED* FOR MY CHILD TO BE TRANSPORTED AND SUPERVISED BY THE FACILITIES STAFF ON FIELD TRIPS AND/OR TO/FROM SCHOOL. I WILL BE GIVEN THE OPPORTUNITY TO APPROVE OR DISAPPROVE OF EACH ACTIVITY. (Must have signature)

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

**WATER ACTIVITIES:** I UNDERSTAND THAT MY CONSENT *MAY BE REQUESTED* FOR MY CHILD TO PARTICIPATE IN WATER ACTIVITIES AS PROVIDED BY PRECIOUS STONES PRESCHOOL. I WILL BE NOTIFIED AS TO THE SPECIFICS OF THE ACTIVITY AND GIVEN THE OPPORTUNITY TO APPROVE OR DISAPPROVE OF EACH INDIVIDUAL ACTIVITY. (Must have signature)

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

**LIABILITY WAIVER:** I, THE UNDERSIGNED PARENT OR GUARDIAN OF THE ABOVE CHILD, HOLD "PRECIOUS STONES PRESCHOOL" OR ANY OF IT'S STAFF, HARMLESS FOR ANY AND ALL INJURIES ARISING WHILE THEIR CARE.

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

**FACILITY PERMISSIONS:** I GIVE MY PERMISSION FOR PRECIOUS STONES PRESCHOOL TO UTILIZE THE FACILITIES AVAILABLE TO THEM WITH MY CHILD IN ATTENDANCE. I UNDERSTAND TTAHT THIS INCLUDES VICTORY CAMP, LIVING STONES CHRISTIAN SCHOOL, AND LIVING STONES CHURCH GROUNDS AND FACILITY.

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

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PARENT OR GUARDIAN COMPLETING THIS FORM

\_\_\_\_\_  
Please print

RELATIONSHIP TO CHILD

\_\_\_\_\_  
Please print

**I ATTEST THAT ALL OF THE INFORMATION PROVIDED TO PRECIOUS STONES PRESCHOOL IS ACCURATE AND IS NOT MISLEADING IN ANY WAY. I WILL KEEP PRECIOUS STONES PRESCHOOL INFORMED OF ANY CHANGES THAT MAY OCCUR WHILE MY CHILD IS ENROLLED AT THEIR FACILITY.**

\_\_\_\_\_  
Signature-Parent/Guardian

\_\_\_\_\_  
Date