- English
- Spanish

Enrollment Date:_______________
Withdraw Date:________________

Little Blessings Child Development Center PreK Program

Child's Information:

Name: ____ Male / Female DOB:_________
Child resides with:_______________________
Special medical conditions (allergies, etc…)

____

Family Information:

Mother / Guardian Name: ____
Address____
Street City State Zip
SS #: ______-____-______ Email: __________________@________.com
Phone #s: Home: _______________Cell: ________________Work: ________________
Employer Name: ____
Employer Address: ____

Father / Guardian Name: ____
Address____
Street City State Zip
SS #: ______-____-______ Email: __________________@________.com
Phone #s: Home: _______________Cell: ________________Work: ________________
Employer Name: ____
Employer Address: ____

Local Emergency Contacts – Not mother or father - You must list two

1. Name: ____________________________ Phone:______________ Home Cell Work (*circle one*)
   Phone:______________ Home Cell Work (*circle one*) Relation to Child:___________________
2. Name: ____________________________ Phone:______________ Home Cell Work (*circle one*)
   Phone:______________ Home Cell Work (*circle one*) Relation to Child:___________________

Others Authorized to pick up your child *(other than emergency contacts)*
Name: ____________________________ Phone:______________ Home Cell Work (*circle one*)
Phone:______________ Home Cell Work (*circle one*) Relation to Child:___________________

Signed:____ **Date:**________________

Physician's Name:___________________________________ **Phone:**____________________
Preferred Hospital: _________________________________ **Phone:**____________________
My child will be attending _____________________________________ **for kindergarten.**

Tuition Agreement

I understand that tuition is subject to change with advance notice.

- Hourly charges are billed each Monday.
- Charges not paid by the Friday of the week billed are considered past due and will be subject to a ***$10 PER DAY*** late fee.
- CYFD Contract families who exceed their allotted contracted hours will be charged $4 per hour in excess of allotment.

Per State Regulations, no child is allowed to be at the center for more than 12 hours per day!

Please fill in your child's schedule: PreK is 8:30 am to 3:30 pm Monday - Thursday

Mon	Tues	Wed	Thurs	Fri	Sat
To	To	To	To	To	To

It is ***your responsibility*** to clock your child in and out each day that your child attends!
To ensure that we have adequate staff to meet all children's needs, please adhere to your schedule. Notify us in advance of any changes you may need to make to your schedule.

CYFD Contract (circle one): Yes No Monthly Co-Pay: ________________________
Hourly charges : $4 per hour outside PreK hours or in excess of your CYFD contract

☐ ***Free NM PreK Program Only (no Registration Fee)***
If child attends outside regular PreK days and hours there will be a $4 per hour charge

Total Due at enrollment (Co-pay or tuition plus registration): ________________________

Little Blessings Child Development Center will provide well balanced, nutritional meals and snacks.
Breakfast: 9am Lunch: 12 Noon Snack: 3pm

I have read and agree to follow all policies and procedures of Little Blessings Child Development Center.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Director ____ Date ___________________

Enrollment Agreement

Mandated by State Licensing Regulations

I/We, the parent(s) of ______________________________, understand the policies and procedures of Little Blessings Child Development Center. I/We agree to abide by the rules and regulations set forth by the director of this facility. I/We further understand that this center is licensed and regulated by the State of New Mexico. I/We understand that all costs associated with child care at this facility and accept responsibility for all charges incurred at Little Blessings Child Development Center. I/We agree not to hold the director, owner, or any staff member responsible for any injury sustained by my/our child while in the care of this facility. Furthermore, in the event of an emergency, I/We give permission for my/our child to be transported to the nearest emergency facility by the most expedient means necessary and that neither staff, nor the director of this facility will be held responsible for injuries sustained to my/our child while in transit.

I have read and agree to follow all policies and procedures of Little Blessings Child Development Center.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Director ____ Date ___________________

Consent for Emergency First Aide & Transportation

I hereby give permission that my child, _________________________________, may be given emergency treatment by a staff member at Little Blessings Child Development Center. I also give permission for my child to be transported by car, ambulance, or other emergency vehicle necessary. I agree to hold Little Blessings Child Development Center and all its employees NOT liable.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Consent for Medical Care and Treatment

In the event that I cannot be contacted immediately, I give permission that any medical treatment deemed necessary by an attending physician may take place. I. again, hold Little Blessings Child Development Center and all its employees NOT liable.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Little Blessings Child Development Center Sick Child Policy and Procedure

Regular school attendance is encouraged. However, a sick child should be kept at home. The following guidelines have been established to determine if a child should be at school. Parents will be called to pick up their child if the following symptoms are present:

1. Diarrhea or vomiting - The child may return when symptoms have ceased for 24 hours.
2. Impetigo – The child may return after antibiotics have been administered for 24 hours, or when sores are dry with NO yellow crust (about 7-10 days).
3. Fever – 100° rectally or 99.4° orally – The child may return when free from fever for 24 hours.
4. General malice (headaches, listlessness) – A child who will not eat or participate in activities does not belong at school.
5. Otis Media (ear ache) – The child should be seen by a physician and may return to school following a minimum treatment of 48 hours.
6. Perdiculosis (lice) – The child may return following a minimum of 48 hours after shampoo treatment has taken place. If any eggs remain, the child will be sent home immediately.
7. Colds – The child may attend school if he/she is free from fever and general malice.
8. Ring Worm or Athlete's Foot – The child may attend school if the infected areas are covered and being treated.
9. Strep Throat – The child may attend school after 24 hours of antibiotic treatment.
10. Conjunctivitis (Pink Eye) – The child may return following 24 hours of treatment with medication prescribed by a medical doctor.
11. Any condition that requires constant care is up to the management's discretion.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Discipline Policy

Mandated by State Licensing Regulations

All staff members employed by Little Blessings Child Development Center will actively attempt to stop a child from continuing a behavior which is dangerous to the child or others, or which is disruptive and/or interferes with group time and/or other activities. Consistency is the key to effective discipline. All staff members employed by Little Blessings Child Development Center will be consistent with the following procedures:

- The staff member will attempt to redirect the child to other activities.
- If behavior continues, the child will be separated for a brief Time Out. All staff will ensure that the child understands what the offense was and what is required to rejoin the group. A representative of Little Blessings Child Development Center will inform the parents of the child of the dangerous or disruptive behavior, should it continue.
- If a child has hurt another, the staff member will try to get the offender to realize his/her responsibility by talking with the children together, helping the offender to notice how the other child feels, and asking what he/she could do to make the other feel better. Apologies are to be encouraged, but may not be forced or used as a requirement to rejoin the group.
- If a child is continuously disruptive or abusive to others or him/her self, either physically or verbally, the following steps will be taken:
  1. The parent will be notified and the problem discussed.
  2. A mutual plan for correction will be adopted.
  3. If the behavior does not improve after the discussion, the director may ask that the child be withdrawn from the center, for reasons beneficial to the child and/or the center, with one week notice, or immediately if the safety and well being of other children or staff members are at risk.

The following disciplinary practices are ***strictly prohibited:***

- Physical punishment of ANY type.
- Withdrawal of food, rest, bathroom access, or outdoor activities.
- Abusive or profane language. This includes yelling.
- Any form of public or private humiliation. This includes threats of physical punishment.
- Unsupervised isolation

Parent's Signature: ____ Date: ___________________

Field Trip Permission

I hereby request that my child be permitted to participate in field trips to the park, or any other activities that would involve taking my child outside of the center for his/her benefit in attendance at this facility.

Parent's Signature: ____ Date: ___________________

General Information and Consent

I have provided Little Blessings Child Development Center with all immunization records for my child and have read information regarding my child's enrollment. I understand that identification may be required before my child is released to unrecognized individuals. I understand that Little Blessings Child Development Center retains the right to disenroll my child if my child's needs are not being met adequately, which is up to the discretion of the center Director. I affirm that all information on the registration form is accurate and true to the best of my knowledge. I am aware that I am welcome at any time to observe my child at Little Blessings Child Development Center, with the understanding that I am to respect the teachers in the rooms and in the confines of the building. I understand that any threatening or belligerent behavior on the part of my child or me may be grounds for disenrollment.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Director ____ Date ___________________

Little Blessings Child Development Center Parent Handbook Acknowledgement

I, ______________________________________, have read and understand the policies and procedures as specified in the Parent Handbook.

By signing the Parent Handbook Acknowledgement, I agree that I have, as stated above, read and understand the policies and procedures set out in the Parent Handbook.

Mother/Guardian ____ Date ___________________

Father/Guardian ____ Date ___________________

Director ____ Date ___________________

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL ______________________________ DATE ______________ 20 ___

NAME OF CHILD Last First Middle	AGE	SEX ☐ M ☐ F	GRADE	SECTION/ROOM

ADDRESS

No. and Street | City or Post Office | Borough/Township | County | State | Zip

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

____
Date of Dental Examination

______________________________ ______________________________
Signature of Dental Examiner Print Name of Dental Examiner

____
Address

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL____ DATE ____________

NAME OF CHILD LAST FIRST MIDDLE	AGE	GRADE	SEX (CIRCLE ONE) M F	HEIGHT INS.	WEIGHT LBS.
ADDRESS NO. AND STREET CITY OR POST OFFICE BOROUGH OR TOWNSHIP COUNTY STATE ZIP					

IMMUNIZATION STATUS: (Give Date of Last Booster and Last TB Test)

	Yes	BASIC (Date)	No	BOOSTER (Date)
TRIPLE ANTIGEN (DPT)				
DTAP				
DIPHTHERIA TOXOID				
TETANUS TOXOID				

POLIO VACCINE	ORAL (Date)	SALK (Date)
TYPE I		
TYPE II		
TYPE III		
BOOSTER		

MMR #1________________, #2__________________

HEPATITIS B (DATES) #1____________, #2____________, #3 ___________

MEASLES VACCINE Type_______________ Date_______________

VARIVAX #1 _______________, #2__________________

PREVNAR ________________________

TUBERCULIN TEST – Type _______, Date _____________, Result _______

MENACTA ________________________

OTHER (SPECIFY) ____

MEDICAL HISTORY: (Give significant details, including serious illness, allergies, operations, accidents, etc.)

REPORT OF EXAMINATION: (Elaborate below on *positive* findings)

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
GENERAL NUTRITION			GLANDS			SKELETON		
SKIN			HEART			POSTURE		
EYES			LUNGS			EMOTIONAL STATUS		
EARS			ABDOMEN			HEARING		
NOSE AND THROAT			GENITALIA (MALE)			SCOLIOSIS (Bending Position)		
TEETH AND GINGIVA			NEURO MUSCULAR SYSTEM					

BLOOD PRESSURE ________________________

VISION: R 20/ L 20/ + LENS
Wears corrective lens Yes _____ No _____

Is the child under treatment? Yes _____ No _____

Should this child have restrictions on play or physical education activities? Recommendations:

What other recommendations do you wish to make to teacher of school nurse which might be of benefit to this child from the point of view of either physical or mental hygiene?

SIGNATURE OF EXAMINING PHYSICIAN ADDRESS TELEPHONE