

Enrollment Date: _____

Withdraw Date: _____

The Learning Curve Child Development Center

Child's Information:

Full Legal Name (*as shown on birth certificate*):

First Name

Middle

Last Name

Preferred name: _____ Gender: _____ DOB: _____

Ethnicity: _____ Race: _____ Hispanic? _____

Tribal Affiliation: _____ Primary language spoken in the home: _____

Child resides with: _____

Family Information:

Mother / Guardian Name: _____

Address _____

Street

City

State

Zip

SS #: _____ - _____ - _____ Email: _____

Phone #s: Home/Mobile: _____ Work: _____

Employer Name: _____ Employer Address: _____

Father / Guardian Name: _____

Address _____

Street

City

State

Zip

SS #: _____ - _____ - _____ Email: _____

Phone #s: Home/Mobile: _____ Work: _____

Employer Name: _____ Employer Address: _____

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

1. Name: _____ Phone: _____

Phone: _____ Relation to Child: _____

2. Name: _____ Phone: _____

Phone: _____ Relation to Child: _____

Others Authorized to pick up your child (*other than emergency contacts*)

Name: _____ Phone: _____

Phone: _____ Relation to Child: _____

Signed: _____ Date: _____

Physician's Name: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Kindergarten Transition Information

What Elementary School will your child attend for kindergarten?

Look up your child's school in the Albuquerque Public Schools District: <https://www.aps.edu/find-my-school/>

Look up your child's school in the Moriarty-Edgewood School District:
<https://www.mesd.us/page/registration>

New Mexico PreK Tuition Agreement

- New Mexico PreK is **FREE** for PreK Days and Hours **ONLY**
- Outside PreK Hours are billed at \$6.50 per hour.
 - Before 8:45am or after 3:15pm
 - Any "No PreK days" as [indicated on our calendar](#)
- **Automatic payments through Tuition Express are required for all families** (as of 4/1/2022)
- Automatic payments may be scheduled on a day other than the 1st or 15th at the discretion of the director.

New Mexico PreK operates Monday through Friday from 9am-3pm
Daily attendance is required to participate in New Mexico PreK
It is ***your responsibility*** to clock your child in and out each day that your child attends!

I have read and agree to follow all policies and procedures of The Learning Curve Child Development Center.

Parent/Guardian _____ Date _____

Director *Ruthie Maffett* Date _____

Automated Payment Processing



Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize The Learning Curve Child Development Center to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

Process my payment on: *Every Monday* *1st of each month* *15th of each month*

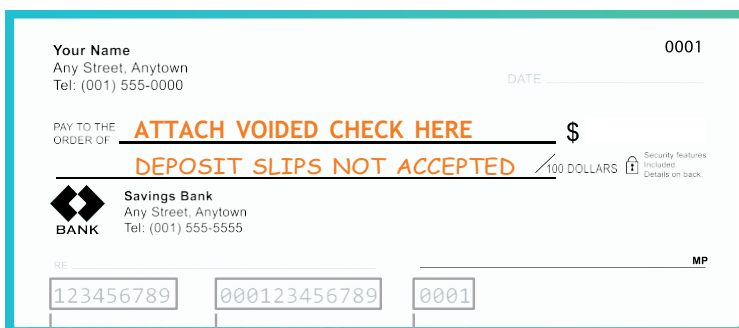
COMPLETE ONE SECTION ONLY (Credit Card or Bank Account)

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date		
Cardholder Signature	Date		

SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received

Health and Developmental Questionnaire

Child's Name: _____ DOB: _____

Date of Last:

Well Check: _____

Dental visit: _____

Vision test: _____

Hearing screening: _____

Do you need resources for: Dental Visit? Vision Test? Hearing Screening?

Has your child had any of these diseases or complications with (check all that apply):

- | | | |
|---------------------------------------|--|------------------------------------|
| <input type="radio"/> Hepatitis | <input type="radio"/> Frequent Sore Throat | <input type="radio"/> Bronchitis |
| <input type="radio"/> Measles | <input type="radio"/> Lice | <input type="radio"/> Diabetes |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Urinary problems | <input type="radio"/> Constipation |
| <input type="radio"/> Fainting Spells | <input type="radio"/> Stomach Upsets | <input type="radio"/> Convulsions |
| <input type="radio"/> Frequent Cold | <input type="radio"/> Asthma | <input type="radio"/> Diarrhea |

Please list any illness not listed above:

Please list any known allergies:

Does your child have any special dietary needs?

If dietary needs do not align with CACFP requirements, we must have written instructions from your child's doctor detailing the specific restrictions/modifications.

Please explain:

Does your child function at the level of other children in his/her age group?

Please explain:

Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group setting?

Please explain:

Does your child currently have an IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan)?

If yes, do you agree to provide us with a copy to better support your child's needs?

Parent/Guardian Signature _____ Date _____

ASQ – CONSENT FORM

The Ages & Stages Questionnaires® (ASQ®) are used to screen young children ages 1 month to 6 years to help determine if their development is on schedule—or if further evaluation may be needed. ASQ also helps parents, together with providers, learn more about a child's strengths and areas that may need support.

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

- I have read the information provided about the *Ages & Stages Questionnaires Third Edition (ASQ-3)* and *ASQ-SE* and I wish to have my child participate in the screening/monitoring program.
- I would like to administer the *ASQ-3* and/or the *ASQ-SE* at home with my child.
- I do not wish to participate in the screening/monitoring program. I have read the provided information about the *Ages and Stages Questionnaires, Third Edition (ASQ-3)* and understand the purpose of this program.

Parent/Guardian Signature

Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, #of weeks premature: _____

Child's primary physician: _____

Enrollment Agreement

Mandated by State Licensing Regulations

I, the parent/guardian of _____, understand the policies and procedures of The Learning Curve Child Development Center. I agree to abide by the rules and regulations set forth by the director of this facility. I further understand that this center is licensed and regulated by the State of New Mexico. I understand all costs associated with childcare at this facility and accept responsibility for all charges incurred at The Learning Curve Child Development Center.

I have read and agree to follow all policies and procedures of The Learning Curve Child Development Center.

Parent/Guardian _____ Date _____

Consent for Emergency First Aide & Transportation

I hereby give permission that my child, _____, may be given emergency treatment by a staff member at The Learning Curve Child Development Center. I agree not to hold the director, owner, company, board members, or any staff member responsible for any injury sustained by my child while in the care of this facility. Furthermore, in the event of an emergency, I give permission for my 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, nor the company, nor its board members will be held responsible for injuries sustained to my child while in transit.

Parent/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 The Learning Curve Child Development Center and all its employees NOT liable.

Parent/Guardian _____ Date _____

Photo Release

The Learning Curve Child Development Center participates in the New Mexico PreK Program, administered by the New Mexico Early Childhood Education and Care Department (ECECD) and the Public Education Department (PED) along with our Contractor, UNM Continuing Education. These partners ask permission to take photographs and/or to videotape your child during their time in the NM PreK classroom. We are asking your permission to take photographs of or film of your child. Copies may be used by us, ECECD, PED or UNM-CE in ongoing research, reports, marketing materials to promote New Mexico PreK, etc. Pictures/film of your child may be used for training purposes or in future professional publications. For all of the above, we require your permission.

If you do not want your child's photograph taken at all, you have the option of declining. Thank you for your cooperation and support.

The undersigned parent or legal guardian does hereby consent for their child to be photographed or videotaped, and does hereby authorize The Learning Curve Child Development Center, the State of New Mexico, or its contractor, UNM- Continuing Education staff to take photographs or videotapes, which will be used for research, training, brochures, reports, marketing, and the like. The undersigned does hereby release The Learning Curve, the State of New Mexico or its contractor, UNM-CE staff from any and all claims for damages for libel, slander, invasion of the right of privacy, or any claims based on the use of said material. This includes compensation of any sort now or in the future, in the event that your child's photograph or videotape is used in any of the aforementioned materials including professional publications, marketing, training, reports, etc. developed by NM PreK and their contractor, UNM Continuing Education. Please check the boxes that apply.

I authorize my child to be videotaped and/or photographed and the use of my child's image for publication in reports, professional articles and books, professional development, and promotional/marketing materials.

I **do not** want my child to be videotaped or photographed.

I CERTIFY all of the following: This form has been explained to me and/or I have read the contents of this form, or the contents have been read to me. I understand the contents of this form and/or the explanation of the contents of this form. All blanks or statements requiring insertion or completion were filled in and all items not applicable were stricken before I signed.

Parent/Guardian Signature _____ Date _____

The Learning Curve Child Development Center Family Handbook Acknowledgment

I, _____, have read and understand the policies and procedures as specified in the Family Handbook. I further understand that updated Family Handbooks are available online at: <http://www.tlcdevelopmentcenters.org/>

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

Parent/Guardian _____ Date _____

General Information and Consent

I have provided The Learning Curve Child Development Center with the following documents (*required PRIOR to first day of attendance*):

- ✓ [Income Eligibility Application](#)
- ✓ Up to date [Immunization](#) Records
(*to be re-submitted each time a new Immunization is administered*)
- ✓ Copy of _____'s Birth Certificate or Hospital Record

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 The Learning Curve 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 The Learning Curve 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 immediate disenrollment.

Parent/Guardian _____ Date _____

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

NAME OF SCHOOL _____

DATE _____

NAME OF CHILD			AGE	GRADE	SEX (CIRCLE ONE)	HEIGHT	WEIGHT
LAST	FIRST	MIDDLE			M F	INS.	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)	POLIO VACCINE	ORAL (Date)	SALK (Date)
	TRIPLE ANTIGEN (DPT)					TYPE I	
DTAP					TYPE II		
DIPHTHERIA TOXOID					TYPE III		
TETANUS TOXOID					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			
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 _____

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

NAME OF SCHOOL _____ DATE _____ 20__

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
<div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Last First Middle </div>		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

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

REPORT OF EXAMINATION

		TOOTH CHART																	
		RIGHT								LEFT									
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
UPPER					A	B	C	D	E	F	G	H	I	J				Upper	
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	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