Child Enrollment Authorization

Child's Name (Last, First)		**Child Nickname**
Date of Birth	**Date Entered Care**	**Age at Entry**

ALLERGY ALERT **Does your child have allergies? ☐ YES ☐ NO If yes, list all allergies on back side of form.**

Parent or Guardian Contact Information

Name (First, Last)			Relationship
Home Address (Street, City, Zip)			
Home Phone	Cell Phone	Email Address	
Employer and Work Hours	Address (Street, City, Zip)		Work Phone
Name (First, Last)			Relationship
Home Address (Street, City, Zip)			
Home Phone	Cell Phone	Email Address	
Employer and Work Hours	Address (Street, City, Zip)		Work Phone

Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child

Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship

Non-Emergency Contact Information – person other than parent or guardian that is authorized to pick up child

Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship

Medical/Dental Contact Information

Insurance Provider and Policy Information (if applicable)	
Primary Physician Name	Phone
Dental Provider	Phone

Parent or Guardian Authorization

Please list any restrictions to permission of the following:

My child may be taken on field trips or excursions by bus or private motor vehicle, as well as on neighborhood walking excursions under required supervision (see special transportation arrangements section on back of form). ☐ Yes ☐ No

My child may participate in swimming or other water activities under required supervision (OCC requires approved lifeguard). ☐ Yes ☐ No

My child may be photographed for publicity or news purposes ☐ Yes ☐ No This applies to ☐ On-site ☐ Off-site photography.

In an emergency, the child care facility has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.

_____ _____

Parent/Guardian Signature Date

Continued on back

Child Information

Has your child previously been in child care? **No** ☐ **Yes** ☐ **If yes, what type of care and for how long?**
Reason for requesting care
Child General Information – please include all information that will assist us in providing quality care for your child
Likes and dislikes
Eating habits and schedule
Toileting habits and schedules
Sleeping habits and Schedule
Play
Fears
How your child like does to be comforted when upset?
Child's home language
Special word and their meanings
Are there family cultural backgrounds, traditions, beliefs, or interests that you would like to share with us?
Does your child have any educational special needs (IFSP, etc.) No ☐ Yes ☐ If yes, List any health partners or providers you would like us to know about.
Child Medical Information
Does your child have special medical needs? No ☐ Yes ☐ If yes, List any health partners or providers you would like us to know about.
Does your child have allergies No ☐ Yes ☐ If, yes list below Has your child had chicken pox No ☐ Yes ☐

Other Children in the Home		
Name (first, Last)	**Age**	**Gender**
Name (first, Last)	**Age**	**Gender**
Name (first, Last)	**Age**	**Gender**
Name (first, Last)	**Age**	**Gender**

Sunscreen Permission Form

Date: _____

Child's Name: _____

Name of Sunscreen and SPF #: _____

Please apply sunscreen to your child every morning before drop off. As needed throughout the day, your child's care provider will assist with applying sunscreen to bare surfaces including the face, tops of ears and bare shoulders, arms, legs, and feet 15-30 min before outdoor activity. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

_____
Parent Signature

Special Instructions:
_____ I do not want my child to use any sunscreen other than the one that she/he brings.

_____ In the event that my child's sunscreen is not readily available, my child may use the sunscreen provided by the school.

_____
Parent Signature

BEND IMMERSION PRESCHOOL
American Sign Language Preschool

Enrollment Application

1. _____ Enrollment fee is $100 per student, a one time fee, not part of tuition.
2. _____ Fee is not refundable, unless a position is not available.
3. _____ This application is valid when accompanied by $100 enrollment fee.
4. _____ Once tuition has been paid, slot will be held for the student.

Child's Name: _____ Birthdate: _____ - _____ - _____
Child's Name: _____ Birthdate: _____ - _____ - _____

Guardian's Name: _____ Referred From: _____
Address _____ Zip _____
Email _____ Phone _____
Cell Carrier: _____

Monday: _____ **-** _____
Tuesday: _____ **-** _____
Wednesday: _____ **-** _____
Thursday: _____ **-** _____
Friday: _____ **-** _____
Requested Start Date: _____ - _____ - _____

Tuition Child 1 $_____
Tuition Child 2 $_____
Total $_____

I/We (parent/guardian)_____, as Client(s) agree to pay $ _____ per month to Bend Immersion Preschool for the time in the schedule below for (student)_____ under the terms and conditions specified in the school handbook. Tuition is assessed monthly and must be pre-paid before childcare/preschool begins. Tuition rates are based on the amount of days and hours selected on this form.

_____ I agree to pay the Late Pay charge of $20 per day, each day my payment is late.

_____ My payment is due on the 1st of this month for next month.

_____ Tuition increase is for January tuition each year.

_____ Notice given this month, makes NEXT month, your last month. Notice is for dropping hours, moving onto kindergarten or moving out of the area.

_____ Adding hours will mean the new tuition needs to be paid and a new tuition form signed, prior to attending.

_____ Accounts not in good standing will be sent to collection. Client agrees to pay all associated fees with collection or court costs.

I have understand and agree to abide by the terms of this agreement.

Signature _____ Date: _____

Paid by: Cash Check _____ Date Contacted for Enrollment _____

Date of Enrollment Meeting _____ Tuition paid _____ Start Date_____

Oregon Certificate of Immunization Status

Certificado de estado de vacunación

Oregon law requires proof of immunization or exemption signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority.

La ley de Oregon requiere que se entregue un comprobante de vacunación o de exención firmado antes de que un(a) menor asista a la escuela, al preescolar, a un centro de cuidado infantil o a una guardería. Esta información se recopila en nombre de la Autoridad de Salud de Oregon y la escuela o el centro infantil, y puede divulgarse a la Autoridad o al departamento local de salud pública, si la Autoridad la solicita.

Child's last name *Apellido del/de la menor*	First name *Primer nombre*	Middle name *Segundo nombre*	Birth date *Fecha de nacimiento*

Parents' or Guardians' names *Nombre de los padres o tutores*	Phone number *Número de teléfono*

Write the dates the child received the vaccines
Indique las fechas en las que el/la menor recibió las vacunas

Vaccines / *Vacunas*	**Dose 1 *Dosis 1***	**Dose 2 *Dosis 2***	**Dose 3 *Dosis 3***	**Dose 4 *Dosis 4***	**Dose 5 *Dosis 5***
Diphtheria/Tetanus/Pertussis *Difteria/tétanos/tos ferina* (DTaP)					
(Tdap)					
Polio (IPV)					
Varicella (Chickenpox) *Varicela*			☐Check if child had chickenpox disease *Marque aquí si el/la menor ha tenido varicela.* Date / *Fecha* _____		
Measles/Mumps/Rubella (MMR) *Sarampión/paperas/rubéola*					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B *Tipo B* (Hib)					

I certify that the information on the form is an accurate record of this child's immunizations.
Certifico que la información en el formulario es un registro exacto de las vacunas de este(a) menor.

Signature* *Firma**		Date *Fecha*	
Update signature *Actualizar la firma*		Date *Fecha*	

* Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations.

* *El padre, la madre, el/la tutor(a), un estudiante de por lo menos 15 años de edad, un proveedor médico o un miembro del personal del departamento de salud del condado puede firmar para verificar las vacunas.*

Child's last name *Apellido del/de la menor*	First name *Primer nombre*	Middle name *Segundo nombre*	Birth date *Fecha de nacimiento*

Other vaccines received ***Otras vacunas recibidas***	
Vaccine name ***Nombre de la vacuna***	**Date** ***Fecha***

Medical exemptions and immunity documentation
Documentación sobre las exenciones médicas y documentación de inmunidad.

Medical exemptions and immunity documentation require a letter signed by a licensed physician submitted to your child's school or child care. For the requirements go to www.healthoregon.org/medicalexemptions

La documentación sobre las exenciones médicas y documentación de inmunidad exige que se le entregue a la escuela o centro de cuidado infantil de su hijo(a) una carta firmada por un médico autorizado. Para ver los requisitos, visite www.healthoregon.org/medicalexemptions

Nonmedical exemption / *Exención no médica*

I have received information regarding the benefits and risk of immunizations. I understand my child may be excluded from school or child care if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

☐ The vaccine module approved by the Oregon Health Authority
☐ A health care practitioner

He recibido la información relacionada con los beneficios y los riesgos de las vacunas. Entiendo que pueden excluir a mi hijo(a) de la escuela o del centro de cuidado infantil si se presenta un caso de enfermedad que podría prevenirse con una vacuna. Adjunto el documento requerido de parte de (marque una opción):

☐ *El módulo de vacunas aprobado por la Autoridad de Salud de Oregon*
☐ *Un proveedor de atención médica*

I request that my child be exempted from the following required immunizations (check all that apply):
Solicito que se exente a mi hijo(a) de las siguientes vacunas requeridas (marque todas las opciones que correspondan):

☐ Diphtheria/Tetanus/Pertussis / *Difteria/tétanos/tos ferina*
☐ Polio
☐ Varicella / *Varicela*
☐ Measles/Mumps/Rubella / *Sarampión/paperas/rubéola*
☐ Hepatitis B
☐ Hepatitis A
☐ Hib

Optional / *Opciona*

Immunizations are being declined because of:
Se están rechazando las vacunas debido a lo siguiente:

☐ Religious belief / *Creencias religiosas*
☐ Philosophical belief / *Creencias filosóficas*
☐ Other / *Otro*

Signature *Firma*		Date *Fecha*	