Parent/Guardian Information

Registration Date: _____

Mother/Guardian

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Occupation: _____ **Cell Phone:** _____

Employed By: _____ **Office Phone:** _____

Work Address: _____ **Work Hours:** _____

Email: _____ **Driver's License#:** _____

☐ **Custodial Parent (If married, mark both parents)**

Marital Status ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐**Widowed** ☐ **Other:** _____

Father/Guardian

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Occupation: _____ **Cell Phone:** _____

Employed By: _____ **Office Phone:** _____

Work Address: _____ **Work Hours:** _____

Email: _____ **Driver's License#:** _____

☐ **Custodial Parent (If married, mark both parents)**

Marital Status ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐**Widowed** ☐ **Other:** _____

Child Information

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: _____ **Phone #:** _____

Address: _____

List any medical conditions, allergies, medication and/or special attention you child may require

_____

Child Information – Continued

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: _____ **Phone #:** _____

Address: _____

List any medical conditions, allergies, medication and/or special attention you child may require

_____

Child Information

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: _____ **Phone #:** _____

Address: _____

List any medical conditions, allergies, medication and/or special attention you child may require

_____

Child Information

First Name _____ **M.I** ____ **Last Name**_____

Address: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: _____ **Phone #:** _____

Address: _____

List any medical conditions, allergies, medication and/or special attention you child may require

_____

Emergency Contacts & Authorized Pickup Persons

1st Contact/Pickup

Name: _____ **Phone#:** _____

Relationship to Child: _____

☐ **Able to pick up all children in the family**
☐ **Not able to pick up the following children:** _____

2nd Contact/Pickup

Name: _____ **Phone#:** _____

Relationship to Child: _____

☐ **Able to pick up all children in the family**
☐ **Not able to pick up the following children:** _____

3rd Contact/Pickup

Name: _____ **Phone#:** _____

Relationship to Child: _____

☐ **Able to pick up all children in the family**
☐ **Not able to pick up the following children:** _____

4th Contact/Pickup

Name: _____ **Phone#:** _____

Relationship to Child: _____

☐ **Able to pick up all children in the family**
☐ **Not able to pick up the following children:** _____

Attendants Schedule

Please specify the days and times your child will be attending.

Day of the week	Drop off time	Pick up time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Financial Agreement

1. **Tuition is billed weekly and payment is due on the first day of each week. You may elect to pay monthly in advance or bi-weekly. A $25 late fee will be assessed if payment is not received when due.**
2. **A $25 fee is assessed for returned checks.**
3. **If two or more children from the same immediate family are enrolled, a 10% discount will be given on the least expensive tuition.**
4. **Registration fee for each school year is $100 per family and is due at time of application for new or returning students. Registration fee is not refundable.**

Additional Comments & Information

Is there any other information that would be helpful to our management and teaching staff?

_____

_____

Parents Signature: _____ **Date:** _____

CDC/SGH# or name:_____

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):_____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? ☐ **No** ☐ **Yes** **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** **If yes**, specify procedure:
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Additional comments:
Other special instructions:

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

BEST OF CARE

This confidential form is to help your child care provider support the growth and development of your child while creating a safe, stable and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH

PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PROVIDER/CENTER NAME

Has your child attended child care in the past? ☐ Yes ☐ No

If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

What did you like most about your child's previous child care setting?

What did you like least?

Other comments:

What is important to you about your child's care?

Who is important to your child?

Does your child prefer to play alone or with other children? ☐ Alone ☐ Other children

Does your child have a favorite toy or comfort object? ☐ Yes ☐ No

If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? ☐ Yes ☐ No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

See reverse for EOE/ADA/LEP/GINA disclosures

CHILD'S NAME

Special things you say or do to comfort your child are?

How do you know when your child is:
Happy?
Sad?
Mad?
Tired?
Other?

How does your child react when:
Something unexpected happens?

Something happens he/she doesn't like?

He/She is scared?

Other?

Does your child have any health issues? ☐ Yes ☐ No
If yes, please explain:

Does your child have any other special needs? ☐ Yes ☐ No
If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? ☐ Yes ☐ No
If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

☐ Parent/Guardian declined to complete

Parent/Guardian Signature

Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

ILLNESS FORM

Every year a number of students become ill because of exposure to other ill children. We have listed indicators to help you decide. If your child displays any of these symptoms, it is suggested that you keep your child home.

1. Fever over 100 degrees. A child should be fever-free for 24 hours without medication before returning to school.
2. Green nasal discharge. A child's nose should be completely clear for 24 hours.
3. Persistent cough
4. Diarrhea. A child should be completely free of diarrhea for 24 hours before returning.
5. Nausea or vomiting
6. Pink eye or eye discharge
7. A rash of unexplained origin
8. If your child has been prescribed an antibiotic, they must be on it for 24 hours before returning to school

Please Note:

Children will be sent home at the teacher's discretion if any of these symptoms are displayed. Our main concern is the best of quality care for your child.

By signing, you are stating you have received and read the Illness Form.

Childs Name_____ Date_____

Parents Signature_____

Release Form for Photographs & Videos

The Springs Preschool + Childcare seeks permission to photograph and/or record videos of you and/or your child(ren) for promotional purposes. These images could appear in promotional material such as but not limited to; newsletters, brochures, bulletin boards, school website and social media accounts.

1. We have permission to use these in our classroom. Yes / No
2. We have permission to use these in our front desk area. Yes / No
3. We have permission to use these in our promotional material. Yes / No
4. We have permission to use these on our school website. Yes / No
5. We have permission to use these on our social media pages. Yes / No

Name of Parent/Guardian_____

Name of child(ren)_____

I hereby grant permission to The Springs Preschool + Childcare to use photographs or videos of me and my child(ren) for promotional purposes and services as indicated above.

Parent Signature_____ Date_____

Parent Handbook Acknowledgement Form

By signing this you are acknowledging that you have read, understand, and are willing to adhere to the policies listed within the parent handbook.

Signature:_____ Date:_____