HARRIS-STOWE STATE UNIVERSITY

William L. Clay, Sr. Early Childhood Development/Parenting Education Center Enrollment Application

Date of Enrollment_____

PERSONAL INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME	CHILD'S M.I.

DATE OF BIRTH _____/_____/_____	GENDER ☐ FEMALE ☐ MALE	HOME TELEPHONE ( )

ADDRESS	CITY	STATE	ZIP CODE

Mother or Guardian Information #1

MOTHER'S OR GUARDIAN'S LAST NAME	MOTHER'S OR GUARDIAN'S FIRST NAME	M.I.

ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )	CELL PHONE (OPTIONAL) ( )

E-MAIL ADDRESS

EMPLOYER (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

EMPLOYER OR SCHOOL ADDRESS	CITY	STATE	ZIP CODE

Father or Guardian Information #2

FATHER'S OR GUARDIAN'S LAST NAME	FATHER'S OR GUARDIAN'S FIRST NAME	M.I.

ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )	CELL PHONE (OPTIONAL) ( )

E-MAIL ADDRESS

EMPLOYER (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

EMPLOYER OR SCHOOL ADDRESS	CITY	STATE	ZIP CODE

Family Demographic Information

OPTIONAL

RACE

☐ ASIAN ☐ BLACK ☐ WHITE ☐ NATIVE AMERICAN

☐ PACIFIC ISLANDER ☐ MULTIRACIAL ☐ UNSPECIFIED ☐ OTHER

SPECIFY HOME LANGUAGE

RELIGION

FAMILY STRUCTURE

☐ MARRIED ☐ LIVING JOINTLY ☐ SHARED CUSTODY ☐ SINGLE PARENT

☐ OTHER_____

EMERGENCY CONTACT INFORMATION (REQUIRED)

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME		
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD		
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME		
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD		
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME		
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD		
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME		
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD		
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME		
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD		
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE

PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY

LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of an accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize **Harris-Stowe State University's William L. Clay, Sr. Early Childhood Development/Parenting Education Center** (DVN# 002144478) to contact the following:

PHYSICIAN OR CLINIC		TELEPHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE
PREFERRED HOSPITAL		TELEPHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE

CHILD'S DOCTOR'S FIRST NAME	CHILD'S DOCTOR'S LAST NAME		
TELEPHONE NUMBER ( )			
ADDRESS	CITY	STATE	ZIP CODE
CHILD'S DENTIST'S FIRST NAME	CHILD'S DENTIST'S LAST NAME		
TELEPHONE NUMBER ( )			
ADDRESS	CITY	STATE	ZIP CODE

FAMILY INFORMATION

Please list the names, ages and genders of the other children in the family.

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

FAMILY INFORMATION (CONTINUED)

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

ANNUAL INCOME (BELOW $65,860 FOR FOOD SERVICE INFORMATION ONLY)
$

COMMENTS ON CHILD'S DEVELOPMENT

Please provide any additional information about the child that may be helpful to his or her teacher.

PLAY HABITS

EATING HABITS

SLEEPING PATTERN

FEARS

LIKES/DISLIKES

SPECIAL LANGUAGE

OTHER

PREVIOUS EXPERIENCE IN CHILD CARE
☐ YES ☐ NO

List any chronic or medical challenges that your child has, e.g., seizures, asthma, diabetes, heart disease, respiratory illness, drug reaction, etc.

Describe any allergies, including any foods that have caused adverse reactions or any food not given to the child for health or religious reasons (use separate sheet if necessary).

Has your child come in contact with tuberculosis?

☐ YES ☐ NO	IF YES, WHEN?

Check the illnesses your child has experienced:

☐ Measles ☐ German Measles ☐ Mumps ☐ Chicken Pox
☐ Scarlet Fever ☐ Strep Throat ☐ Rheumatic Fever
☐ Other_____

TRANSPORTATION TO AND FROM SCHOOL

DO YOU GIVE PERMISSION TO THE FACILITY TO TRANSPORT YOUR CHILD TO AND FROM SCHOOL? ☐ YES ☐ NO			
SCHOOL CHILD ATTENDS		TELEPHONE ( )	
ADDRESS	CITY	STATE	ZIP CODE

FIELD TRIPS

I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSIONS AND THAT I WILL BE NOTIFIED WHEN THEY ARE PLANNED.

ACKNOWLEDGMENTS

A)	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.
B)	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.
C)	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.
D)	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT HE OR SHE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.

AUTHORIZATION AND VERIFICATION

This application must be accompanied with a signed medical statement and updated immunization record at the time of admission to child care and is to be renewed annually. At the time of admission, the undersigned parent or guardian understands that care will be billed at the rate of $_____, based on _____ hours per week. A nonrefundable fee of $100 is required at the time of enrollment of which $50 will be applied to the first payment. Please make checks payable to Harris-Stowe State University. Further, I certify that the facts contained in this application are true and complete to the best of my knowledge.

PRINT NAME	
SIGNATURE	DATE _____/_____/_____

APPLICATION SUBMISSION

Please return all completed applications to William L. Clay, Sr. Early Childhood Development/Parenting Education Center Director Patricia Johnson either in person by going to Room 207 of the early childhood center or by mailing the application and check to:

Dr. Patricia Johnson
Harris-Stowe State University
10 North Compton Avenue, Room 207
St. Louis, MO 63103

TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

FACILITY NAME	ADMISSION DATE
ENROLLED FOR (DAYS OF THE WEEK)	FULL TIME/PART TIME
HOURS PER DAY FROM TO	DISCHARGE DATE

Updated October 25, 2010