All Saints Catholic School Childcare
768 Ohio Street
Bangor, Maine 04401
(207)941-9585

PRESCHOOL ENROLLMENT APPLICATION
2019-2020 SCHOOL YEAR

Office Use

Check number: _____
Admittance Date: _____ Date of Dismissal:_____

Medical Conditions/Allergies:_____
Classroom Assingment:_____
Half Day_____ Full Day _____

Child's Name:_____ Nickname:_____

Address:_____ Home Phone:_____

Gender:_____ Birthday:_____ Grade:_____ Age as of Sept. 1st_____

Child's Ethnicity:
(Please check one. We are responsible for reporting the following information in our annual reports)

_____American Indian _____Asian _____Native Alaskan _____Black _____Multi-racial
_____Hispanic _____Native Hawaiian _____Pacific Islander _____White

Child's Religion:_____ Church Attending:_____

Person's Having Legal Custody of Child

Name:_____ Relationship to Child:_____
Home Address:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email Address:_____
Occupation:_____
Business Address:_____

Name:_____ Relationship to Child:_____
Home Address:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email Address:_____
Occupation:_____
Business Address:_____

If a custody arrangement or agreement exists, explain and attach supporting documentation (including pertinent visitation agreements, or a copy of the court decree). If any of the above information changes, please inform us immediately

Siblings

Name	Age	Birthdate

Child Release Information

Children will not under any circumstances be released to any person without the expressed consent to do so by the child's custodial parent(s) or guardian(s). Prior to pick up, please inform the childcare office if someone other than yourself or those listed below are picking up your child.

Name:_____ Contact Phone:_____ Relationship to child:_____

Name:_____ Contact Phone:_____ Relationship to child:_____

Name:_____ Contact Phone:_____ Relationship to child:_____

Please list any other childcare facilities your child has been involved in:

Place	Date(s)

Potty Trained Children

In our childcare center we cannot enroll children who are not completely potty trained. We understand a child may have an occasional accident. If your child is not completely potty trained, they will be asked to leave the facility until they have become fully trained. This is mandated by our childcare licensing through the State of Maine Department of Health and Human Services.

Please sign below stating that you understand this information.

Parent signature:_____ Date:_____

Registration

Please specify which days and hours you will need. We are open for childcare daily from 6:46 am to 5:30 pm. We are also open on snow days, vacation days and school vacation days.

Monday: _____ Hours: _____

Tuesday: _____ Hours: _____

Wednesday: _____ Hours: _____

Thursday: _____ Hours: _____

Friday: _____ Hours: _____

Emergency Information

Persons to be called in case of an emergency if custodial parent(s) or guardian(s) are unavailable.

Name:_____ Relationship to child:_____
Home Address:_____ Phone Number:_____
Business Address:_____ Business Phone Number:_____

Name:_____ Relationship to child:_____
Home Address:_____ Phone Number:_____
Business Address:_____ Business Phone Number:_____

Name:_____ Relationship to child:_____
Home Address:_____ Phone Number:_____
Business Address:_____ Business Phone Number:_____

Medical Record and History

(To be completed by parent/guardian)

Present general health: _____
Special needs: _____
Past serious illness: _____
Medications your child takes:
_____

PLEASE NOTE: If your child requires medication to be administered at school please complete an Authorization to Dispense Medication Form, available upon your request.

Child's Physician and Phone Number: _____
Child's Dentist and Phone Number: _____

Does your child see any other doctors besides their physician or dentist? _____
If yes, please explain: _____
_____

1. Does your child have any medical issues? (For example: asthma, epilepsy, etc.) Yes _____ No _____
   If yes, please explain: _____

2. Have there been any previous hospitalizations? Yes _____ No _____
   If yes, please explain:_____

3. Any allergies? Yes _____ No_____
   If yes, please explain._____

4. Any previous diseases or illnesses? Yes _____ No_____
   If yes, please explain. _____

5. Any operations? Yes_____ No_____
   Dates: _____

6. Any physical handicaps? Yes_____ No_____
   If yes, please explain:_____

7. Is there any history of convulsions or seizures in child? Yes _____ No _____
   If so, please explain. _____

8. Is there any history of diabetes in child? Yes _____ No _____

9. Is there any history of diabetes in family? Yes _____No _____

10. Is there any history of heart trouble in child? Yes _____ No _____

11. Is there any history of heart trouble in family? Yes _____ No _____

12. Is there any history of developmental delays in child? Yes _____ No _____
    If so, please explain. _____

13. How would you describe your child's disposition?_____
    _____

14. What are your short-term educational, social, and emotional goals for your child?
    _____
    _____
    _____

15. What are your child's special interests?_____
    _____
    _____

Agreements

Hospital Preference _____(initial)

I, _____, hereby give authorization to All Saints Catholic Child Care and its employees to obtain emergency medical treatment for my child in the event of sudden illness or injury.

Hospital preference, if any _____

Sunscreen and Insect Repellant _____(initial)

I, _____, give permission for my child _____

To have **sunscreen:** Yes _____ No _____

To have **insect repellant** Yes _____ No _____

Permission will allow staff to apply the above as needed. I will supply sunscreen labeled for my child as needed.

Photos _____(initial)

I, _____, give permission for All Saints Catholic Child Care personnel to:

Photograph my child for brochure of All Saints Catholic Child Care Program
Yes _____ No _____

Photograph my child for use within the classroom (non-publicity)
Yes _____ No _____

Include my child's class picture in the All Saints Catholic School Yearbook
Yes _____ No _____

Photograph my child for picture on the website.
Yes _____ No _____

Thirty Day Trial Period Agreement Form

I, _____, consent and agree to a thirty day trial period for _____ dating from his or her first attendance at All Saints Catholic Child Care.

I understand that if, at any time during this thirty day trial period, the child does not show signs of adjusting or is not ready for this type of preschool experience, based improper behavior, emotional disturbances, or mental health conditions too severe to be handled by the staff in this environment.

_____ _____
(Administrator's Signature) (Parent/Guardian Signature)

_____
(Date)

Fee Agreement

I agree to the following conditions regarding care for my child by All Saints Catholic Child Care.

The tuition fee for child care services is to be paid weekly on Wednesday. If the fee is not paid in any two week period, services may be terminated until the fee is collected, unless arrangements are made with the Director. If the child is sick, on vacation, or otherwise absent, the fee is still due and payable.

We require two weeks' written notice if your child will be leaving or changing enrollment status (i.e., full time vs. part time change in status).

FEES ARE AS FOLLOWS:

Please note these are weekly charges. **PRICES ARE SUBJECT TO CHANGE.**

5 full days (M-F 6:45 am to 5:30 pm)	$160.00
5 half days (M-F 8:00 am to 12 noon)	$120.00
3 full days (M/W/F 6:45 to 5:30)	$120.00
3 half days (M/W/F 8:00 to 12 noon)	$77.00

WEEKLY FEE: (based on hours indicated on page 3) _____

There is a 10% discount given to second preschool child enrolled from the same family.

I understand that payment is due in by means of either of the following.

_____**Tuition Express Weekly Debits –** The checking or savings account on record will be debited weekly for the amount due, per your Fee Agreement.

_____**Prepay –** Prepayment to be made on September 5th (fall semester), January 2nd (winter/spring semester), and June 18th (summer semester).

I understand that I am paying for the availability of a preschool slot and therefore will be charged even when my child is not in attendance.

Parent's Signature: _____ Date:_____

Administrator's Signature:_____ Date:_____

Physical Exam

(to be completed by child's physician)

PATIENT'S NAME _____

WEIGHT _____ HEIGHT _____ HEART_____

CHEST _____ THROAT _____NECK _____

ABDOMEN _____ GU _____EXT. _____

NEUROLOGICAL SYSTEM _____

TEETH _____SKIN _____HEAD _____

EYES _____EARS _____

RESULTS OF TUBERCULIN TEST, IF GIVEN _____
(Type) (Results)

SHOULD ACTIVITIES BE LIMITED? _____

WHAT ACTIVITIES SHOULD BE ENCOURAGED? _____

RECOMMENDATIONS? _____

_____
Signature of physician

_____
Date of exam

_____
Office address and telephone number

Immunization Records

(to be completed by child's physician)

PATIENT NAME:_____ DATE OF BIRTH:_____

DTAP/DTP/DT/TETRA _____
DTAP/DTP/DT/TETRA _____
DTAP/DTP/DT/TETRA _____
DTAP/DTP/DT/TETRA _____

ADULT TD _____

OPV/IPV _____
OPV/IPV _____
OPV/IPV _____
OPV/IPV _____

HEPTB/HIB _____
HEPTB/HIB _____
HEPTB/HIB _____
HEPTB/HIB _____

MMR _____
MMR _____

PNEUMOCOCCAL CONJUGATE
PREVNAR _____
PREVNAR _____
PREVNAR _____
PREVNAR _____

HIB _____
HIB _____
HIB _____
HIB _____

VARICELLA _____
PPD/TINE T _____

FLU _____

ALLERGIES _____
CONTRACTED DISEASES _____
EXEMPTIONS FROM VACCINATIONS:
MEDICAL _____RELIGIOUS _____