Pathways School Enrollment Checklist

(Please bring all of the items listed below to enroll your child)

- Completed Registration Packet (all sections signed and dated by parent or guardian)

- Signed Health Statement signed by pediatrician stating they are healthy and able to attend school (request separately from pediatrician's office)

- Copy of immunization records or exemption form

- Vision and Hearing screens (for students 4 years and older)

- Payment (cash, check or credit card is accepted. Amount is the first month of tuition + $100 annual supply fee)

REG. DEPOSIT amt. _____ (_____/_____) (CASH/ CHECK/CREDIT) SUPPLY FEE $100_____ (CASH/CHECK/CREDIT) CK # _____ DATE OF ADMIT:_____ WITHDRAW:_____	2M-F_____ 2MWF_____ 2TTH_____ 3M-F_____ 3MWF_____ 3TTH_____ 4M-F_____ 4MWF_____ 4TTH_____ K_____ BSC_____ ED_____ T-SHIRT SIZE: YXS YS YM YL

Pathways School

A Ministry of the Dripping Springs United Methodist Church

Operation Name: *DSUMC Pathways School* ***Director:*** *Mary Fernandez* ***Program Year:*** *2018-2019*

Child's Full Name: _____ Name Child Goes By: _____

Date of Birth: _____

Child Lives with (please check one): ___ Both Parents ___ Mom ___ Dad ___ Other (specify)

*****Should the child be under the legal custody of only one parent, a copy of the final court judgment must be on file at DSUMC Pathways School*****

Child's Physical Address: _____

City_____ Zip Code _____

Child's Mailing Address: _____

City _____ Zip Code _____

Home Phone Number: _____

Parent (preferred contact person): _____

Cell Number: _____

Work Number: _____ Email: _____

Parent : _____ Cell Number: _____

Work Number: _____ Email: _____

EMERGENCY AND RELEASE INFORMATION

RELEASE INFORMATION:
I authorize Pathways staff to allow my child to leave the facility with the following people: ____(initial)

1. _____ Phone #

_____

2. _____ Phone #

_____

3. _____ Phone #

RESTRICTED PERSON: The following people are to have NO contact with my child: ____ (initial)

1._____2._____Phone #__ 3. _____

4. _____

_____

5. _____ Phone #

EMERGENCY CONTACTS: These people are authorized to pick up and AND supervise medical treatment, if the parents/guardians cannot be reached. ___(initial)
NAME, PHONE NUMBER, ADDRESS & RELATIONSHIP MUST BE COMPLETED.

1. Name: _____ Home Phone: _____ Cell Phone: _____
Address :_____ Relationship: _____

2. Name: _____ Home Phone: _____ Cell Phone: _____
Address :_____ Relationship: _____

3. Name: _____ Home Phone: _____ Cell Phone: _____
Address :_____ Relationship: _____

4. Name: _____ Home Phone: _____ Cell Phone: _____
Address :_____ Relationship: _____

5. Name: _____ Home Phone: _____ Cell Phone: _____
Address :_____ Relationship: _____

INSURANCE/PHYSICIAN/HOSPITAL INFORMATION

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency attention, I authorize the facility Director or person in charge, to take my child to:

Dr: _____ Address: _____ Phone: _____

Medical Care Facility Preference, if needed _____

Address: _____ Phone: _____

I give my consent for DSUMC Pathways to transport and secure necessary emergency treatment when my child is in the care of Pathways School.

X Signature of Legal Parent or Guardian _____ Date: _____

INSURANCE COMPANY: _____ POLICY # _____

MEDICAL INFORMATION

My child has the following food allergies _____

List any special problems that your child may have, such as allergic reactions, allergies, existing illnesses, previous serious illnesses, serious injuries or hospitalizations during the past 12 months, any prescription medication taken on a continuous basis, or any other information the staff and caregivers should be aware of.

_____

_____

X Signature of Legal Parent or Guardian _____ Date: _____

Child daycare operations are under the American's with Disabilities Act (ADA) Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 414-0301 (voice) or (800) 514-0383 (TTY).

HEALTH ADMISSION REQUIREMENT

One of the following must be presented when your child is admitted to the Pathways School or within one week of admission. Initial to indicate the option you select.

Please initial only one option:

_____ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above child named within the past year and find that he/she is physically able to take part in the school's program.

* Health Care Professional's Signature: _____ Date: _____

_____ A signed and dated copy of a health care professional's statement is attached.

_____ Medical Diagnosis conflicts with the tenets and practices of a recognized religious organization which I adhere to or am a member of; I have attached a signed and notarized affidavit stating this.

_____ My child has been examined within the last year by a health care professional and is able to participate in the school program. I will obtain a health care professional's signed statement and will submit it to the Pathways School.

Name and Address of health care professional: _____

X Signature of Legal Parent or Guardian _____ Date: _____

___ IMMUNZATION RECORD OR EXEMPTION FORM IS ATTACHED**

VISION	R20/ _____	L20/ _____	☐ Pass ☐ Fail
Signature: _____			

HEARING	1000Hz	2000Hz	4000Hz	☐ Pass ☐ Fail
R				
L				

Signature:_____	Date: _____

****VISION AND HEARING ARE ONLY REQUIRED FOR CHILDREN AGES 4 & OLDER****

HEALTH REQUIREMENTS

Name of Child:	**Date of Birth:**

Age ▶ / *Vaccine ▼*	**Birth**	**1 mos**	**2 mos**	**4 mos**	**6 mos**	**12 mos**	**15 mos**	**18 mos**	**19-23 Mos**	**2-3 Yrs**	**4-6 Yrs**
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)	☐ Positive	☐ Negative	Date

Signature or stamp of a physician or public health personnel verifying immunization information above

_____ _____

Signature *Date*

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about _____ (date) and does not need varicella vaccine.

_____ _____

Parent's signature Date

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

PERMISSIONS AND ACKNOWLEDGEMENTS

PARENTAL PERMISSIONS

Transportation

I hereby give ___ do not give ___ my consent for my child to be transported and supervised by the facilities and staff on to and from field trips from Pathways School, to and from designated locations, per operational policies, and for emergency needs.

Field Trips

I hereby give ___ do not give ___my consent for my child to participate in on and off campus field trips.

Water Activities

I hereby give ___ do not give ___ my consent for my child to participate on water activities such as water tables, wading pools, inflatable houses with water and sprinklers.

Information

I hereby give ___ do not give ___ my permission for my child's contact information to be included in a class roster created by the teacher for the families in his/her class that year.

Photo Release

I hereby give ___ do not give ___ my permission for my child's photo to be taken and used for the following: Pathways Primer, bulletin boards, class projects, advertising on the DSUMC website, social media sites, advertising brochures, and posters on and off campus and the church, and student directory within the understanding that only the Primer, bulletin board, class projects and student directory may include my child's name.

I hereby give ___ do not give ___ my permission for photos of my child to be put on a CD to be given out as an end-of-year gift to all parents with pictures of the year, with the understanding that all parents will only use these for their child's memory records.

X Signature of Legal Parent of Guardian _____Date: _____

HANDBOOK ACKNOWLEDGEMENTS

I have received a copy of the DSUMC – Pathways School Parent handbook, which explains policies, Including those for discipline and guidance.

X Signature of Legal Parent or Guardian _____Date: _____

I acknowledge that I have read the entire health, lice, and allergy section of the Pathways School Parent Handbook. I will not bring my child to Pathways School if I suspect (s)he is sick or had other health/allergy lice concerns mentioned under the health and allergy section of the handbook. I will pick up my child(ren) promptly if Pathways School calls and my child has become sick, has nits or live lice or other condition listed in the handbook.

X Signature of Legal Parent or Guardian _____Date: _____

ENROLLMENT

Tuition and Late Fee Policies Acknowledgement

I acknowledge that I have read the entire Tuition and Late Fee section of the Parent Handbook and I agree to abide by those terms.

X Signature of Legal Parent or Guardian _____ Date: _____

I have listed everything on the school forms to the best of my ability. Any changes made to this enrollment form must be made in writing by the parent or legal guardian of this child. Changes must be initialed and dated on the proper forms. Parents are responsible for updating this information upon changes, including but not limited to: address, phone numbers, e-mail addresses, emergency contacts, release information, restricted persons information, health information, and immunization records.

By signing this you are stating that you understand and are liable to pay the full tuition for the months that you have stated your child will attend Pathways School. Written notice of your withdraw requires 30 days notice. You will be responsible for the tuition during the 30 days.

X Signature of Parent or Legal Guardian _____ Date: _____

INSECT SPRAY

We will be outside on our playground daily for recess and would like to have your permission to use mosquito repellent.

_____ I give permission for Pathways Staff to use mosquito repellent on my child.
(OFF insect Repellent, Family Care)

_____ I have included my own brand of mosquito repellent to be used on my child.

The brand is: _____

____ I DO NOT want any repellent used on my child.

X Signature of Legal Parent or Guardian: _____ Date: _____