Enrollment Packet

- **Return completed packet with registration fee.**
- **Provide physical and immunization forms.**
- **All diaper cream and sunscreen permission forms must be updated annually and must be signed by your health care provider.**
- **A copy of the parent handbook has been provided by hard copy or e-mailed to you for your review.**
- **For your convenience, Wendy is available to notarize your forms.**

NAC Accredited

Safelutions Certified

1010 Lake Miriam Dr.
Lakeland, Florida 33813
863-646-9333
preschool@pchighlands.com

State of Florida Department of Children and Families
Child Care Application for Enrollment

Student Information: Date of Birth: _____Sex:_____

Date of Enrollment: _____

Full Name: _____
Last First Middle Nickname

Typical Hours of Care: From _____ To _____

Family Information : Child Lives With: _____

Phone # that I prefer to be called on during the day : _____

If I cannot be reached at this number, please call: _____

Mother's Name: _____ Father's Name:_____

Address: _____ Address: _____

City/State/Zip: _____ City/State/zip: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation:_____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

E-Mail: _____ E-Mail: _____

Custody: Mother_____ Father_____ Both_____ Other _____

Primary Language Spoken at Home: _____

Medical Information:
I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child. In the event of an emergency and/or which time I cannot be reached, I give consent to transport by ambulance if the situation warrants it. I understand that I am responsible for providing my insurance information and for any fees incurred. I release Presbyterian Church in the Highlands leaders and employees from any liability for damages, losses, diseases or injuries incurred which may arise from the activities of this program.

Doctor: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Hospital Preference: _____

Allergies: _____

Medications: _____
_____
_____

Please list and attach information from your Health Care Provider regarding any special medical, dietary needs, behavioral or other areas of concern:
_____
_____
_____
_____
_____
_____

Other Helpful Information:
_____
_____
_____

Contacts:
My child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

_____
Name Phone #1 Phone #2

_____
Name Phone #1 Phone #2

_____
Name Phone #1 Phone #2

_____
Name Phone #1 Phone #

Please initial next to each of the following statements and sign below with a Notary.

_____Rule 65C-22.006(2), F.S.C., and Section 65C-20. .011(1), F.A.C. require a current physical examination (DH 3040) and immunization record (DH680 or DH681) within 30 days of enrollment.

_____Section 402.3125(5), F.S. requires that parents receive a copy of the Child Care Facility Brochure, *"KNOW YOUR CHILD CARE FACILITY"* (see handbook for copy)

_____65C-22.006 states that annually, during the months of August and September, the child care facility director must provide parents with information detailing the causes, symptoms, and transmission of the influenza virus. Please refer to the brochure, CF/PI 175-70, *Influenza Virus, Guide to Parents* found in your parent handbook and review it during August and September for this important information.

_____Section 65C-22.006(4)2, F.A.C. requires that parents are notified in writing of the disciplinary practices used by the child care facility. (see handbook for PCH's discipline practices)

_____ I am aware of and give consent for my child to have developmental screenings, including Teaching Strategies Gold. I know that I will have the results shared with me through a parent conference. Pictures and/or video may be include as part of the assessment. Child Assessment results may be shared with the Early Learning Coalition of Polk County, United Way, and FL DOE.

_____By signing below, you verify that you have received the above items and that all information on this enrollment form is complete and accurate.

_____By signing below, you also acknowledge that you have received a copy of the PCH Parent Handbook and agree to the policies and procedures outlined in the handbook. You also acknowledge that you have been oriented to the program with the items outlined on the Family Orientation Form.

Photograph/Media Release

☐ I, the undersigned, do hereby grant permission to ***Precious Children in the Highlands*** to use the image of my child. Use may include the display, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials, videos, and digital images for use within the preschool and/or classrooms only. Children's names will not be attached to any images.

☐ Deny permission to use my child's image.

_____ _____

Signature of Parent/Guardian **Date**

State of Florida
County of Polk

On the_____ Day of_____, in the year_____

Before me came_____

To be known to me personally or who has produced a Florida Dr. License # _____

As identification and who did not take an oath.

_____ _____

Notary Public Print Name

Medication Policy

Medication administration will be limited to situations where an agreement to give medicine outside child care hours cannot be made. It is recommended that parents/caregivers give medication before or after care, or come in over their lunch hour. The first dose of medication shall be given at home to see if the child has any type of reaction. PCH will only administer medications used to prevent breathing and/or allergic emergencies such as a nebulizer/inhaler or EpiPen. Non-prescription topical creams such as **diaper rash ointment and sunscreen** can be administered as needed as long as this medication form is completed. **Written consent from the parent and health care provider needs to be documented on this medication permission form along with detailed dosage instructions.** The medicine or cream/s need to be in the original container and will be stored in a locked box while in the preschool.

Authorization for Prescription and Non-Prescription Medication

Child's Name: _____ DOB: _____

Medication Name: _____

Amount to be Given: _____

Time to be Given: _____

This authorization form must be maintained and is only valid for the duration of the prescription.

I hereby give permission to dispense the medication listed above in accordance with the written directions on the prescription label or printed manufacturer's label.

_____ _____
Parent/Guardian Signature Date

_____ _____
Health Care Provider Signature and/or stamp Date

_____
Health Care Provider Clinic Name, Address and Phone

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