Please complete this form and return it to the Little Lambs Preschool Office. A non-refundable family registration fee of $45 must accompany the application.

Little Lambs Preschool Registration

Student Information:

Student Name: _____ Birth Date: _____ Gender M F

Address: _____City, State, Zip _____

Parent Info.	Mother/Guardian	Father/Guardian
Name		
Address: (only if different from student)		
Home Phone:		
Cell Phone:		
Email (print clearly)		
Employed by		
Work Address:		
Work Phone:		
Work Schedule:		

Student lives with (check all that apply): __Both parents __Mother __Mother and Stepfather __Father __Father and Stepmother

__Grandparent __Other legal guardian (please specify) _____

Student's Siblings (Names and Dates of Birth)

Name_____ DOB _____

Name_____ DOB _____

Name_____ DOB _____

I currently have a church family?
___Yes ___ No

Medical History:

	Yes	No	Explain any "yes" answers below:
1. Does student wear glasses?			
2. Any eye deficiencies or vision problems?			
3. Any hearing problems or deficiencies?			
4. Any speech problems?			
5. Any serious early child health problem?			
6. Any current health problems? (i.e. asthma, seizures)			
7. Currently on medication?			
8. Any food allergies or allergies to medicines?			
9. Any behavior disorders?			
10. Any special needs?			

Class time runs from 8:00-11:30am.

☐ My child is in good health, is able to participate in group activities, and has no special health or medical requirements.

☐ My child is able to participate in group activities, but has special health or medical requirements as listed below:

_____

Any additional information or comments that you wish to share with the teaching staff: _____(use the back)

Please circle the days you would like your child to attend:

I wish for my child to attend the Mon / Tues / Wed / Thurs / Fri Class meeting from 8-11:30am

If your child does not meet the usual age requirements, please speak with Mrs. K or Miss Brandi Preschool Director about enrollment questions. We will take children in pull ups in potty training

Next school year 2023 – 24 my child will attend the following school: _____

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Registration Fee Paid: _____ check #_____ Date Received: _____

Supply fee(s) _____ check#_____ Date Received: _____

Little Lambs Registration

Student Name _____

Parent/Guardian _____

What is the best way to reach someone if we should need to during a Little Lambs session? Check one provide the number:

☐ Home: _____ ☐ Mom's Cell Phone: _____ ☐ Mom's Work: _____

☐ Dad's Cell Phone: _____ ☐ Dad's Work: _____

Transportation Instructions and Emergency Contact Information:

☐ If I am unable to pick my child up, or in the case of emergency I cannot be reached, I authorize the Little Lambs staff to contact and release my child to the following person(s):

First Contact: _____ Relationship to child: _____

Address: _____ Phone: _____

Second Contact: _____ Relationship to child: _____

Address: _____ Phone: _____

Third Contact: _____ Relationship to child: _____

Address: _____ Phone: _____

Is there anyone who should NOT be allowed to pick up your child? YES NO If yes, who? _____

Emergency/Medical Instructions:

☐ I agree to keep my child home if he/she has a fever or has had a fever in the last 24 hours, or has any signs of a communicable disease. I will also notify the Little Lambs staff of any communicable disease my child has.

☐ In case of an accident or serious illness, I request the Little Lambs staff to contact me. If I cannot be reached, I authorize the Little Lambs staff to contact the physician indicated below and to follow his/her instructions. If this is not possible, I authorize the Little Lambs staff to make whatever arrangements seem necessary up to and including hospitalization.

Name of preferred hospital _____ Hospital Phone: # _____

Insurance Carrier _____ Group # _____ ID # _____

Physician's Name _____ Phone: _____

Parental Commitments:

☐ I pledge my full support of the program of Christian education provided for my child in Little Lambs Preschool.

☐ I accept my financial responsibility for providing preschool for my child and pledge to make my tuition payments in full and on time each month. If I am ever unable to make a full payment when payment is due, I will speak to the preschool director and make arrangements to pay the balance in a manner that is acceptable to both my situation and the well-being of the school.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH 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

TO CONTACT THE FOLLOWING: DAY CARE PROVIDER

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

PLEASE ALSO COMPLETE PAGE 2.

ACKNOWLEDGEMENTS		
A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

HEALTH REPORT FOR SCHOOL-AGE CHILD
CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

☐ MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

☐ MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS

ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS

PARENT/GUARDIAN SIGNATURE	DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.

Little Lambs Registration

Missouri Department of Health and Senior Services
Section for Child Care Regulation

Child Immunization History

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

IMMUNIZATION HISTORY

	DATES GIVEN (Month, Day, Year)					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
DPT/DT/DTaP						
Polio						
Hepatitis B						
Hib						
MMR						
Varicella (chicken pox)						
Pneumoccal Prevnar.						

NAME OF HEALTH CARE PROVIDER FOR THE ABOVE IMMUNIZATIONS:

Missouri Department of Health and Senior Services
Section for Child Care Regulation

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

CHILD'S NAME	BIRTHDATE

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on _____/_____/_____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months)

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

BCC-6A