First Friends
PRESCHOOL

First Friends Enrollment Form

Katie Burgess, Director

Child's Name _____ Sex _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

email for school use _____ Hm Phone _____

Mother's Name _____ Cell number _____

Father's Name _____ Cell number _____

Father's Work Phone _____ Mother's Work Phone _____

Parent address if different from child _____

EMERGENCY CONTACT PERSON: In the event that either parent cannot be contacted or cannot pick up their child, these persons can act of the parent's behalf and are authorized to pick up at First Friends. **Please include at least 2 contacts. All information must be included.**

Name	Address, City, State & Zip	Phone Number
1.		
2.		
3.		
4.		

Please initial the following:

First Friends "Parent Handbook" & "Discipline & Guidance" policy are both located on our website: www.firstfriendspreschool.org, under the registration tab. Click on "Parent Policies".

1. _____ RECEIPT OF PARENT/STUDENT HANDBOOK I acknowledge receipt of the "Parent Handbook" & will adhere to it's policies

2. _____ RECEIPT OF DISCIPLINE & GUIDANCE POLICY I acknowledge receipt of the "Discipline & Guidance" policy

I give consent for photographs and/or video to be taken of my child while at First Friends. I understand that some photographs will be submitted to the Prosper Press, or could be put on the First Friends website or First Friends Facebook page.

Signature of Parent _____ Date _____

For office use only:

Date of Admission _____ **Date of Withdrawal** _____

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HEALTH ADMISSION REQUIREMENTS

FBC Prosper
Katie Burgess, Director

STUDENTS NAME: _____ DOB: _____

HEALTH STATEMENT: (Check One)

( ) Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.

_____ _____
Health Professional's Signature Date

OR

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

OR

( ) Medical diagnosis and treatment conflict with the tenants and practices of a recognized organization which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

IMMUNIZATION REQUIREMENTS: (Check One)

( ) I have attached a copy of my child's current physician immunization record.
My child had Varicella disease (chickenpox) ( ) No ( ) Yes, Date _____

OR

( ) I am excluding my child from the immunization requirements for reason of consciences, including a religious belief. I have attached an official affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years. *For additional information regarding immunizations, contact the Department of State Health Services at: http://www.dshs.state.tx.us/immuize/school_info.htm*

HEARING & VISION REQUIREMENT FOR 4 & 5 YEAR OLDS: (Check One)

( ) I have attached a copy of my child's Hearing and Vision Results
Hearing Results must include Hearing frequencies (1000, 2000, & 4000 Hertz)
Vision must include distance acuity (20/20, 20/30, etc)

OR

( ) I will use Metroplex Education Consultants to provide this service, for the cost of $16.00

OR

( ) Hearing & Vision Requirements are not applicable to my child because he/she is under 4 years of age.

Signature of Parent: _____ Date: _____

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FBC Prosper

Katie Burgess, Director

Name of Child: _____ **DOB:** _____

MEDICAL TREATMENT AUTHORIZATION

I, _____, give First Friends permission to obtain emergency medical treatment for my child. If the physician listed below cannot be reached, permission is granted for another licensed physician to be called.

Child's Physician_____ Physician's Phone_____

Address_____

Hospital Preference_____ Address & Phone_____

Medical Plan_____Group Number_____ Policy Number_____

Allergies & Medical Needs

Allergies: _____

(If none, please write NONE above)

List any special needs: _____

_____

_____

_____

_____

Signature of Parent: _____

Date: _____

Food Allergy Diagnosis

First Friends Preschool 2020-2021

Child's Name: _____

Date of Birth: _____

Parents' Name: _____m

Parent's Contact Phone Number: _____

Allergies & Medical Needs:

------ My child has **not** been diagnosed by a health-care professional.

------ My child **has** been diagnosed by a health-care professional.

If you checked "yes" to your child being diagnosed by a health-care professional, then please contact your physician and have them submit to First Friends a food allergy emergency plan that is specific to your child and includes:

1. a list of each food the child is allergic to;
2. possible symptoms if exposed to a food on the list; and
3. the steps to take if the child has an allergic reaction.
4. the physician's signature and date
5. and the parent's signature and date

First Friends
PRESCHOOL

Food Allergy Emergency Plan

Child's Name: _____

Date of Birth: _____

Parent's Name: _____

Parent's Contact Number: _____

Has your child been diagnosed with Food Allergies: Yes or No

List of Allergies: _____

_____

_____

List of Possible Reactions to Food Allergies: _____

_____

_____

_____

_____

Steps to be taken if the child has an allergic reaction: _____

_____

_____

_____

_____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____