Shelby Hills Early Childhood Center/Wilma Valentine Childcare

CHILD ENROLLMENT INFORMATION

Child's Name_____ **Date of Birth**_____

Address_____

Parent/Guardian_____ **Cell Phone**_____**TEXTING __ yes __ no**

Home Address_____ **Home Phone**_____

Employer Name_____ **Work Phone**_____

Medicaid #_____ **EMAIL** _____

Parent/Guardian_____ **Cell Phone**_____**TEXTING __ yes __ no**

Home Address_____ **Home Phone**_____

Employer Name_____ **Work Phone**_____

EMAIL _____

Please list two people to be contacted in the event of an emergency **IF THE PARENT CANNOT BE CONTACTED:**

Name	Name
Street Address	Street Address
City	City
State ZipCode	State ZipCode
Relationship to Child	Relationship to Child
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

One Call Now System

The Shelby County Board of Developmental Disabilities uses the One Call Now notification system to inform individuals and families of program delays, closures and emergencies. This automated dialer allows us to make recorded phone calls to all individuals and families in a matter of minutes.

Each family may provide up to three (3) phone numbers. All of the phone numbers will be called by the notification system. If you need to revise these numbers, please contact Shelby Hills Preschool/ Wilma Valentine Childcare so we can update your information.

Phone Numbers:

_____

_____

_____

_____ I choose **not** to be part of the One Call Now System _____

Signature & Date

ANNUAL CLASS ROSTER & PHOTO PERMISSION:

Each year we prepare a roster for each group of children in our program. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster:
Please circle one

My Child's Name	Yes	No
Parent/Guardian's Name	Yes	No
Phone Number	Home Cell Work	No

Photo/Social Media Release:

I give my permission for my child's photo to be used in promotional literature, the website/webpages and/or social media, including but not limited to Facebook, Twitter and YouTube. ☐ YES ☐ NO

_____

Signature of parent/guardian (*must be signed and dated)* ***Date Signed***

CHRONIC PHYSICAL PROBLEM (S)
HISTORY OF HOSPITALIZATION:
DISEASES THIS CHILD HAS HAD:
SEIZURE (S) (current treatments and past reactions):
ALLERGIES (current treatments and past reactions):
MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLUORIDE SUPPLEMENTS:

List of Person(s) to whom this child can be released: (Please print) ***Name, Title, Phone #***

List of Person(s) **NOT PERMITTED** to pick up this child: (Please print) Restraint papers/divorce decree attached

	YES NO
	YES NO
	YES NO

IMPORTANT: Please attach a copy of your child's immunization records

EXEMPT FROM IMMUNIZATIONS	**PLEASE CIRCLE ONE**	
Religious conviction	**YES**	**NO**
Other:		

Parent/Guardian's signature for immunization exemption:

_____

COMPLETE SECTIONS A & B

SECTION A

Emergency Medical Authorization

PART I CONSENT

I hereby give consent for the following medical care providers and local hospital to be called for my child (Print Name)_____:

Doctor's Name_____ Phone No. _____

Dentist's Name_____ Phone No. _____

Medical Specialist_____ Phone No. _____

Local Hospital_____ Phone No. _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Date Signature of Parent/Guardian

OR

Part II REFUSAL OF CONSENT (do not complete this part if you completed Part I)

I do **NOT** give my consent for emergency medical treatment of my child (Print Name)_____

in the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action for my child:_____

_____

_____ _____

Date Signature of Parent/Guardian

SECTION B

Emergency Transportation Authorization

___**THE PROVIDER** has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

OR

___**THE PROVIDER does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment

_____ _____

Date Signature of Parent/Guardian