Casa de Amigos, LLC Preschool
40180 Patty-Jo Lane, Prairieville, LA (225) 677- 8686

CASA DE AMIGOS, LLC
PRESCHOOL

Registration Packet

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STUDENT MASTER CARD

Date of Enrollment_____

Child's Name _____ Date of Birth _____

Social Security #_____Sex _____

Home Tel. No. _____ Address _____Zip_____

Father's Name _____ Social Security Number _____

Father's Employer _____ Work #_____ Cell #_____

Mother's Name _____ Social Security Number _____

Mother's Employer _____ Work#_____ Cell#_____

Person(s) with whom child lives_____

Person to call in an emergency when parents cannot be reached_____

Relationship to child_____Daytime #_____Cell#_____

CHILD'S PHYSICIAN_____Tel. No._____

In regards to the child describe the following, if applicable:

Past illnesses _____

Handicapping condition _____

Habits _____

Likes/Dislikes/Favorite Food_____

Ability to play with other' children _____

Toilet training _____

Other (specify) _____

Transportation arrangements - List primary person that will pick up and drop off child: _____

_____Parent(s) or someone else _____

Other Person(s) to whom child may be **RELEASED**_____

I hereby authorize this facility:

1. to care for my child during the time he or she is in the facility, or participating in a facility sponsored field trip and **2.** in accordance with the provisions of Louisiana Civil Code Art. 2997(7), I hereby authorize the Director of Casa de Amigos or his\her designee, to administer and/or obtain emergency medical treatment for my child while under their care, in the event that said Director or his\her designee is unable to contact me.

I have read and agree to abide by the rules in the Parent Handbook.

Parent's Signature_____

* An $80.00 enrollment fee must accompany this registration packet in order to hold a position for your child at the facility.

STUDENT MASTER CARD CONTIN…

EMERGENCY MEDICAL INFORMATION

Child's Name _____Date of Birth _____

Address _____

Home Phone _____ Cell Number _____

Father's Name _____ Cell Number_____

Father's Employer _____ Work Number _____

Mother's Name _____ Cell Number _____

Mother's Employer _____ Work Number _____

OTHER PERSONS TO BE CALLED IN CASE OF EMERGENCY

1._____Tel. No. _____Cell_____

2._____Tel. No._____Cell_____

3. _____Tel. No._____ Cell _____

PHYSICIAN/HOSPITAL TO BE CALLED IN CASE OF EMERGENCY

Name: _____ Tel. No. _____

Address: _____Zip _____

Which hospital should be called _____ Tel. No. _____

Dentist to be called _____ Tel. No. _____

If desired doctor or dentist is not available, may we call a licensed doctor: ( ) Yes ( ) No

NAME OF INSURED _____

INSURANCE CARRIER _____ Policy number _____

Allergies _____

Medication _____Cardiac Defect _____

Food Allergies _____ Diabeties _____

Bee Sting Allergies _____Convulsions _____

Other _____

Date of last Tetanus Shot _____

I reviewed a written description of the center's program, policies, fees, daily schedule and discipline policy.

Parent's Signature _____Date _____

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DO NOT FILL OUT IF YOU CAN PROVIDE A SHOT CARD FROM PEDIATRICIAN

HEALTH & IMMUNIZATIONS

Child's Name _____Date of Birth _____

Parent's Name _____

Date and results of Tuberculin Test _____

Child's General Health _____

Allergies _____

Childhood Diseases _____

Specify any physical handicaps or limitations in activities recommended _____

_____

This child has been examined by me on this _____(date) and is free of any contagious or infectious diseases.

STATE OF LOUISIANA EXPIRATION DATE Month_____Day_____ Year _____

CHILD CARE-PRESCHOOL (Enter the date that the next immunization is due above)

CERTIFICATE OF IMMUNIZATION

VACCINE	**MONTH, DAY AND YEAR EACH DOSE WAS GIVEN**				
	First	Second	Third	Fourth	Fifth
DTP / DtaP / DT					
OPV / IPV					XXXXXXXX
HIB			.		XXXXXXXX
HBV				XXXXXXXX	XXXXXXXX
MMR			XXXXXXXX	XXXXXXXX	XXXXXXXX

I certify that this child has received the above noted immunizations and is in compliance with the rules set forth by the State of Louisiana, Department of Health and Hospitals, and Office of Public Health until the expiration date above.

Date_____ Physician's Signature _____

Address _____Telephone No._____

Third Party Authorization Release Form

I authorize the staff of Casa de Amigos, LLC to release my child, _____to the person or persons listed below. A picture ID is required before the child can be released. If the name does not appear below, by state regulations, we can not release your child. Phone calls will not be accepted as a release authorization. I understand the terms listed above.

Parent(s) Signature_____ Date _____

Names (Please print full/complete names and nicknames used by child)

NAME/Relationship to child PHONE NUMBER

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10_____

EMERGENCY RELEASE FORM

I authorize the child care center to arrange transportation in case of accident or acute illness and to arrange for possible emergency medical and/or surgical care at (1) the closest hospital available in case of dire emergency or (2) the hospital of the parent's choice. It is understood that a conscientious effort must be made to notify me or _____before such action is taken. If it is impossible to locate me or the- person named above, the uninsured expense of this service will be accepted by me.

Parent's Signature _____Date _____

Parent's Signature _____ Date _____

(Both parents must sign if it is required by your health insurance company.)

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Child's Name _____
Parents Names _____
DOB _____
Phone # _____
Date Starting _____

FINANCIAL AGREEMENT

TUITION PLANS: Plan A (5 days/week) Plan B (3 days/week MWF)
Plan C (2 days/week Tu,Th)

5 DAYS

Plan **A** : MONTHLY- **MTWTF**

Preschool (5 days a week M-F) .....$_____ x 9 months =_____

3 DAYS

Plan **B** : MONTHLY - **MWF**

Preschool (3 days a week **MWF**) .....$_____x 9 months =_____

2 DAYS

Plan **C**: MONTHLY - **TU TH**

Preschool (2 days a week **Tu,Th)**.....$_____x 9months =_____

PAYMENT OF FEES:

1. All fees are to be paid according to amount recorded on this financial agreement. **Weekly** tuition is to be paid on **Mondav** of each week. **Monthly** tuition must be paid by the **1st of each month**. Absences, Ascension Parish School Holidays or voluntary non-use or partial use of tuition plans while enrolled does not diminish charge to parents, all monthly fees are a flat rate.
2. The enrollment fee does not go toward tuition, nor is it refundable.
3. Delinquent accounts are subject to a late charge of$5.00 per week, and $50.00 per NSF check.
4. Fees and terms of payment are subject to change with two weeks notification.

TERMS:

I/we agree that if my/our child has met all the admission requirements, I/we will pay the $ **80.00** registration fee, the $**50.00** supply fee, and the tuition fee of $_____per/month. The school reserves the right of dropping the child, after a trial period, who does not fit into the school's program, or whose parent does not cooperate with the school.

I/We hereby further agree that in the event this account is turned over to an attorney for collection, I/We agree to pay all attorneys and court fees together with all costs of collection.

I/We have read the payment of tuition and terms, and understand that enrollment in the services requested will remain in force, and I/We will be charged for them, until I/We cancel the enrollment.

The enrollment can only be cancelled with a **written notice** submitted to the school office **two weeks prior** to withdrawal, or the termination of services by the school. I have been given and have read the Casa de Amigos Parent Handbook.

Father_____ Witnessed by _____

Mother _____

Date _____ Date _____