**New Life Christian Early Learning Center**

Attention: Kim 2795 Patterson Drive, Aliquippa, PA 15001

**Complete both sides and return with $45.00 Registration Fee**

Registration Fee is ***Non-Refundable***

Email: nlcelc@comcast.net Phone: 724-378-6066

Please make check payable to**: NLCELC**

Date:_________________

**Student Information**

Child's name:_____________________________________

Birth Date:______________________ Sex M/F (please circle)

Age on September 1st_______________

Child's home address:________________________________________

Child's home phone number:_________________________________

**Parent or Guardian Information**

Father's name: ______________________________________________

Address: ____________________________________________________

Phone: _____________________Cell phone: _____________________

Employer(s) name and Phone: _______________________________

Mother's name: ______________________________________________

Address: ___________________________________________________

Phone: ____________________ Cell phone: _____________________

Employer(s) name and Phone: _______________________________

**Family Information:**

Brothers and/or sisters and their ages: _________________________

____________________________________________________________

**Emergency information**

Name and number of person to be contacted in emergency:

____________________________________________________________

Health Insurance: ____________________________________________

Special disabilities of child: ___________________________________

Special medical or dietary information: ____________________________

Date child was toilet trained: ________________________________

Child's previous School/ Daycare experience:_________________

Do you have any concerns about your **child's speech**:___________

Transportation will be supplied by:_____________________________

Person to whom child may be released- specify all persons other than parents:____________________________________________________

School district in which you reside: _____________________________

Have you had a child previously attend at New Life? __________

How did you hear about us?______________________________

**PLEASE COMPLETE BACK OF FORM**

Please read and sign:

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It is my understanding that medical care, if required will be paid by me. I also understand that an adult must attend any field trip with New Life Christian Early Learning Center and must stay with their child for the entire fieldtrip. It is also my understanding that I am responsible for providing refreshments approximately one day per month (Prep Class) or approximately once every six weeks (Pre-kindergarten) as assigned. I understand that tuition is based on a yearly fee that is payable in monthly installments. I understand I am responsible for the entire school year tuition. I agree to pay the first day school is in session for the month and no later than the 5th of each month. I agree to the policies of the school as outlined in the policy manual.
SIGNATURE OF PARENT OR
GUARDIAN________________________________

Email Address:_________________________________

**ALL CHILDREN MUST BE IMMUNIZED TO ATTEND NO EXCEPTIONS**

Class preference upon availability (circle):

Prep Class: $800.00 year or $100.00 a month (Sept-April no payment May)

Morning: Tues/ Thurs 9:15 -11:30 AM
(Must be 3 years of age by September 1st and Potty Trained)
at the start of our school year

Pre-Kindergarten: $880.00 year or $110.00 a month (Sept-April no payment May)

Morning: Mon/ Wed/ Fri 9:15 - 12:00
(Must be 4 years of age by September 1st at the start of our school year)

| Office use only | | | | |
|---|---|---|---|---|
| Fee paid | Check | Cash | Date | Initials |
| | | | | |

# CHILD HEALTH REPORT

**(55 PA CODE §§3270.131, 3280.131 AND 3290.131)**

Parent/Provider fill in this part.

| CHILD'S NAME: (LAST) | (FIRST) | PARENT/GUARDIAN: |
|---|---|---|
| DATE OF BIRTH: | HOME PHONE: | ADDRESS: |
| CHILD CARE FACILITY NAME: | | |
| FACILITY PHONE: | COUNTY: | WORK PHONE: |

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Parents may write immunization dates; health professional should verify and complete all data.

**DO NOT OMIT ANY INFORMATION**

**This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.**

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**

| | |
|---|---|
| **VISION (subjective until age 3)** | |
| **HEARING (subjective until age 4)** | |
| **LEAD** | |

**RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD**

| IMMUNIZATIONS | DATE | DATE | DATE | DATE | DATE | COMMENTS |
|---|---|---|---|---|---|---|
| HEP-B | | | | | | |
| ROTAVIRUS | | | | | | |
| DTAP/DTP/TD | | | | | | |
| HIB | | | | | | |
| PNEUMOCOCCAL | | | | | | |
| POLIO | | | | | | |
| INFLUENZA | | | | | | |
| MMR | | | | | | |
| VARICELLA | | | | | | |
| HEP-A | | | | | | |
| MENINGOCOCCAL | | | | | | |
| OTHER | | | | | | |

| MEDICAL CARE PROVIDER: | | SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT |
|---|---|---|
| ADDRESS: | | TITLE: |
| | PHONE: | LICENSE NUMBER: DATE FORM SIGNED: |