

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



Registration Packet

STUDENT MASTER CARD

Date of Enrollment _____

Child's Name _____ Date of Birth _____

Social Security # _____ Sex _____

Home Tel. No. _____ Address _____ Zip _____

Parent #1's Name _____ Social Security Number _____

Parent #1's Employer _____ Work # _____ Cell # _____

Parent #2's Name _____ Social Security Number _____

Parent #2'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 \$ _____ 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 _____

Parent #1's Name _____ Cell Number _____

Parent #1's Employer _____ Work Number _____

Parent #2's Name _____ Cell Number _____

Parent #2'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 _____

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					XXXXXXXXXX
HIB					XXXXXXXXXX
HBV				XXXXXXXXXX	XXXXXXXXXX
MMR			XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

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 #1's Signature _____ Date _____

Parent #2's Signature _____ Date _____

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

This page is Intentionally Blank