ENROLLMENT, EMERGENCY INFORMATION AND AUTHORIZATION FOR TREATMENT & TRANSPORTATION

Peace Early Learning Center ~ 5675 Field Street, Arvada, Colorado 80002 ~ ELC (303) 431-4494 ~ Fax (303) 940-7683

School Year ____________________ Date of Enrollment: __________________

Child Information

Child's Last Name: ______________________________ First: ____________________ Middle: ____________

Nickname: _________________________ Gender: M / F Date of Birth: ___/___/_____

Child's Address: ____

City: ____________________________ State: __________ Zip: ___________ Phone: _____________________

Parent/Guardian Information (If Different From The Child's)

Name:	Name:
Relationship:	Relationship:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Employer:	Employer:
Employer Phone: Ext.:	Employer Phone: Ext.:
Employer Address:	Employer Address:

Special Instructions for Reaching Parent or Guardian: ____

Emergency Contacts (Other than Parents/Guardians listed above):

Name	Relationship	Phone	Address

Authorized People to Pick Up Child (Other than Parents/Guardians and Emergency Contacts)

Name	Relationship	Phone	Address

If there are any restraining orders against anyone having contact with your child, please let your child's teacher and the ELC Director know.

The information provided above is true and accurate and I give my permission for the Early Learning Center Staff to release my child to the individuals listed above.

Parent/Guardian Signature: ____ Date: _____________

Parent/Guardian Signature: ____ Date: _____________

(Fill out both sides please.)

Child's Last Name: ________________________________ **First Name:** ____________________

Medical Insurance

Does your child have a health care plan ? Yes / No

*If yes, the health care plan (a copy of your insurance card) must be provided on or before the first day the child is in care.

Insurance Company: ____

Group #: ____________________ Policy #: ____________________ Expiration Date: ________________

Doctor Information Name: ______________________________ Phone: ____________________

Address: ____

Dentist Information Name: ______________________________ Phone: ____________________

Address: ____

Hospital of Preference (Please check one)

___ Children's Hospital, 3455 Lutheran Pkwy Ste 230, Wheat Ridge, CO 80033 (720) 777-1370
___ Children's Hospital, 7577 W 103rd Ave Unit 200, Westminster, CO 80021 (720) 777-1330
___ Lutheran Medical Center, 8300 West 38th Avenue, Wheat Ridge, CO 80033 303-425-4500
___ Kaiser Permanente Affiliate, Children's Hospital Colorado, 1835 Franklin Street, Denver, CO 80218 720-777-1360
___ Other____

Health History

Allergies/Reactions____
Chronic Illnesses/Special Needs____
Operations or serious injuries (dates)____
Physical limitations: Yes / No Describe if yes. ____
Dietary limitations: Yes ? No Describe if yes. ____
Is the child on any medications? Yes / No ____
If yes, please describe____
Is your child fully immunized ? Yes / No

* * * * **Completed immunization records must be provided on or before the first day the child is in care.**

Photography At Peace Early Learning Center

By enrolling your child in the Peace Early Learning Center, you give permission for photos of your child's activity in the Early Learning Center to be taken and used for learning, promotional or historical purposes. When used for promotional purposes, names will be omitted.

Nap Cots

I give permission for my child to rest on a cot provided by Peace Early Learning Center.

Participant Waiver

I give my permission for the child listed above to participate in all learning experiences at Peace Early Learning Center, including but not limited to classroom instruction, chapel, indoor and outdoor experiences, on and off campus experiences. I will assume full responsibility for the medical care of my child for any injury incurred during participation in the Peace Lutheran Early Learning Center.

Electronic Key

I agree to notify Peace if my electronic key becomes lost or misplaced. I also agree to pay the fee if I do not return the key by my child's last day of school. I will not allow others access to the building when using my key. I agree to the full policy in the Parent Handbook.

Authorization For Emergency Medical Care And Transportation:

I hereby give my permission to Peace Early Learning Center to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care including transport to the nearest health care facility for my child, ____________________.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed. Treatment, however, will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

The information provided above is true and accurate and I agree to the statements listed above.

Parent/Guardian Signature: ________________________________ Date: ________________

Parent/Guardian Signature: ________________________________ Date: ________________

(Fill out both sides please.)