

St. Matthews Child Development Center

229 Breckenridge Lane
Louisville, KY 40207
(502) 896-2798

ADMISSION FORM

Please promptly inform SMCDC of any changes to the information listed below.

Child's Full Name: _____

Birth date: ____/____/____ Enrollment Date: ____/____/____

Mother's (or guardian's) Name: _____

Phone Number: _____ E-mail Address: _____

Address: _____

Employer: _____ Work Phone: _____

Father's (or guardian's) Name: _____

Phone Number: _____ E-mail Address: _____

Address: _____

Employer: _____ Work Phone: _____

With whom does the child reside: _____

Person(s) authorized to take child from the facility – Name/Relationship/Phone number:

I agree that the following forms and documents shall be kept on file at the Center:

- Current Immunization Record
- Original Enrollment Forms
- Accident Reports
- Originals or copies of any correspondence

MEDICAL HISTORY

Child's Physician: _____ Phone Number: _____
Preferred Hospital: _____

Does your child have any allergies? If so, please list:

Has your child's physician placed any restrictions on his or her participation in activities? If so, please describe:

Please list any other medical conditions or information that we should be aware of:

*In the event of a health-related emergency, your child will be transported via ambulance to the nearest hospital.

HEALTH EMERGENCY RELEASE

In the event of an emergency involving in my child, I authorize SMCDC staff to provide basic first aid to my child. I further authorize SMCDC staff to obtain, on my behalf, any medical care deemed necessary by treating physicians to ensure the health and safety of my child.

Any costs or fees relating to such medical services will be my responsibility. I agree to indemnify and hold harmless SMCDC for any resulting costs, fees, and/or results of said emergency.

Initials: _____

PLAYGROUND RELEASE

I authorize my child to use the play equipment and participate in all SMCDC on-site activities. Off-site activities will be authorized with separate releases.

Initials: _____

POTTY TRAINING AGREEMENT

Potty training can be easily accomplished when parents and teachers work together. Consistency and preparedness are key. When your child is ready to potty train, please send him or her in clothing that is easy to remove quickly. Also be sure to have several sets of extra clothing and pull-ups on hand in the event of accidents.

I authorize SMCDC to help potty train my child. I agree to work with my child's teacher to make potty training a success!

Initials: _____

DIAPERING RELEASE

The Kentucky Cabinet for Health and Family Services requires that we obtain permission to use wipes and diapering creams on your child. I understand this requirement and grant SMCDC permission to use wipes and diapering creams on my child as necessary.

Initials: _____

EMERGENCY EVACUATION

If it becomes necessary to evacuate the center, children will be transported to Harvey Browne Church. Infants and toddlers will be evacuated in wheeled evacuation cribs. All other children will walk with their respective classes holding a bunny-ear rope.

I understand that my child will be transported to the designated location mentioned above in the event of an evacuation from the center.

Initials: _____

My signature below indicates I have read and understand the above policies. I have also received and reviewed a copy of the parent handbook.

Signature: _____ Date: _____

ST. MATTHEWS CHILD DEVELOPMENT CENTER

"A fun place to learn"

PHOTO RELEASE FORM

I, _____, the parent/legal guardian of _____, hereby give St. Matthews Child Development Center, its successors and assigns and those acting with its authority, the unqualified right and permission to reproduce, copyright, publish, circulate or otherwise use any school pictures of my child produced by St. Matthews Child Development Center. This authorization and release covers the use of said school pictures in any published form and any media of advertising publicity.

I also understand that our school may be identified by name and I fully understand that this is a complete release of all claims against St. Matthews Child Development Center or any other person, firm or corporation by reason of any such use of such school pictures.

I also understand that my child's name will not be used, printed, or otherwise noted on any photograph, website, or any other advertisement.

I hereby warrant that I am free to give this permission for myself and my child. I further warrant that the information I have provided is, to the best of my knowledge, true and accurate.

Signature of Parent/Guardian: _____ Date: _____

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DIAPER CREAM/SUNSCREEN/BUG SPRAY FORM

Child's Full Name: _____ **DOB:** _____

Diaper Cream

Brand/Name: _____

Dates to be used (max. one year) from: ____/____/____ to ____/____/____

Please select from one of the following amounts to administer the diaper cream:

Amount to apply: (select one)

___ Pea-sized amount

___ Dime-sized amount

___ Quarter-sized amount

Please select from one of the following times to administer the diaper cream:

Times to apply: (select all that apply)

___ Whenever redness occurs

___ Whenever rash is present

___ At every diaper change

Sunscreen

Brand/Name: _____

Dates to be used (max. one year) from: ____/____/____ to ____/____/____

Instructions: Please apply the above named sunscreen on my child to cover and protect his/her exposed skin before going outside to play.

Bug Spray

Brand/Name: _____

Dates to be used (max. one year) from: ____/____/____ to ____/____/____

Instructions: Please apply the above named bug spray on my child to cover and protect his/her skin before going outside to play.

Additional Notes: _____

Parent Signature: _____ Date: _____

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PERMISSION TO ADMINISTER MEDICATION

I HEREBY AUTHORIZE THE STAFF OF ST. MATTHEWS CHILD DEVELOPMENT CENTER to administer the following medication to my child, _____, according to these instructions. I understand the staff cannot be responsible for any allergic reactions from this medication if given according to the directions. **MEDICINE WILL NOT BE GIVEN WITHOUT A DOCTORS NOTE/PRESCRIPTION, AND CHILDS NAME ON ORIGINAL BOTTLE.**

Medication: _____

Dosage: _____

Dates to be given: _____

Times to be given: _____

Refrigerate: _____ Yes _____ No

SIGN IN	DATE	SIGN OUT

Record of Medication Administration:

DATE	TIME	AMOUNT GIVEN	STAFF INITIALS

Special Instructions:

For Office Use Only:

- Immunization Certificate
- Admission Form/Medical History/Releases
- Parent Handbook
- Photo Release Form
- Diapering Cream/Sunscreen Form
- Permission to Administer Medication Form