

**St. James Warm Hearts Child Care and Learning Center  
Registration Form**

Child's Name \_\_\_\_\_  
Last First Middle

Nickname \_\_\_\_\_

Street Address \_\_\_\_\_

City State Zip Code

Home Phone \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Siblings \_\_\_\_\_ Child Lives With \_\_\_\_\_

\_\_\_\_\_ Home e-mail \_\_\_\_\_

**Father's Information**

**Mother's Information**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

E-mail \_\_\_\_\_

**St. James Warm Hearts Child Care and Learning Center  
CONTRACT**

Name of Child \_\_\_\_\_

Name of Parents \_\_\_\_\_

Enrollment Date \_\_\_\_\_

- 1) The parent/s agrees to pay a rate of \$ \_\_\_\_\_ a week regardless of their child's attendance. The parent/s agree to make weekly payments on Monday by the 6 p.m. closing time. A charge of \$25.00 will be assessed on all returned checks. If 2 checks are returned, the parent will pay weekly in cash. If the parent is late, there will be a charge of \$10.00 for every 10 minutes late. Each family will be given 2 weeks a year of free child care.
  
- 2) A \$30.00 registration fee will be assessed per child or \$50.00 per family assessed per year.
  
- 3) Parents need to give at least a 2 week notice of their intent to leave the center.
  
- 4) A four (4) week probationary period will be given to all children to adjust to staff, schedules and routines. St. James Warm Hearts Child Care and Learning Center reserves the right to terminate the contract at its discretion.

- 5) Parents agree to provide all the supplies needed to care for their child; examples: diapers, formula and/or breast milk, Pull-ups, extra clothes, blanket, and travel pillow.
  
- 6) If your child becomes ill, you will be called to pick up your child or send an emergency contact person. Please have them bring a picture ID.
  
- 7) If your child needs medicine, you must sign a written authorization form with the name, dosage and times to be given. Please leave in original container. To be able to administer an epi pen, inhaler, or breathing treatment, we must have the doctor's written permission and specific instructions to be allowed to give.
  
- 8) The parents are aware that Christian beliefs, songs and prayers will be taught periodically during the day.
  
- 9) Parents agree to abide by policies in the handbook. The parent has received, read and understands the terms of the St. James Warm Hearts Child Care and Learning Center handbook.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Director's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Emergency Contact Information**

1. Contacts Name \_\_\_\_\_

Street Address \_\_\_\_\_

Relationship to Your Family \_\_\_\_\_

Phone Numbers \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

2. Contacts Name \_\_\_\_\_

Street Address \_\_\_\_\_

Relationship to Your Family \_\_\_\_\_

Phone Numbers \_\_\_\_\_

**Others Authorized to Pick Up Your Child**

Names \_\_\_\_\_

\_\_\_\_\_

Phone Numbers \_\_\_\_\_

Relationship to Your Family \_\_\_\_\_

Hours Your Child Needs Care \_\_\_\_\_

## Health and Release Information Form

Current Health Issues \_\_\_\_\_

\_\_\_\_\_

Medication child is currently uses on a regular basis \_\_\_\_\_

\_\_\_\_\_

Allergies (penicillin, asthma, seasonal allergies, foods, soaps) \_\_\_\_\_

\_\_\_\_\_

Physical Limitations \_\_\_\_\_

Has your child been diagnosed with an injury or illness that we should be aware of? \_\_\_\_\_

Child's Physician \_\_\_\_\_

Office Phone \_\_\_\_\_

Office Address \_\_\_\_\_

I will be notified in the case of a medical emergency. I hereby give St. James Warm Hearts Child Care and Learning Center permission to seek immediate medical attention to my child if an emergency should occur. I understand that St. James Warm Hearts Child Care and Learning Center is not responsible for medical expenses incurred, but that such expenses will be the responsibility of the parent or guardian.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Photo Authorization Form

I hereby grant St. James Warm Hearts Child Care and Learning Center the right and permission to use and publish photographs/ film/video/electronic representations and/or sound recordings made of myself and/or my child/children by St. James Warm Hearts Child Care and Learning Center. I hereby release St. James Warm Hearts Child Care and Learning Center from any and all liability from such use and publication. At this time, no photographs will be used on the church website.

I hereby authorize the reproduction, copyright, exhibit, broadcast, electronic storage and/or distribution of said photographs/film/video tapes/electronic representations and/or sound recordings of the child care center. I waive the right to any compensation I may have for any of the foregoing. I understand that no photos will be released by St. James Warm Hearts Child Care and Learning Center to any organization without my written permission.

Name \_\_\_\_\_

Child's Name/Names \_\_\_\_\_

Date \_\_\_\_\_

**Medication Competency Statement**

I, \_\_\_\_\_ have determined  
 Parent /Guardian Name

\_\_\_\_\_ competent to give or apply medication to my child(ren).  
 Provider/Director

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**CHILD'S MEDICAL INFORMATION**

Any health problems which caregiver should know: \_\_\_\_\_

Medication, if any: \_\_\_\_\_

Allergies, if any: \_\_\_\_\_

Special Concerns: (Glasses, Hearing Aid, Crutches) \_\_\_\_\_

Any activities child(ren) should NOT engage in: \_\_\_\_\_

Company providing health and/or accident insurance coverage: (Optional) \_\_\_\_\_

**Certificate of Immunizations**

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given			DOCTOR OR CLINIC ADMINISTERING
				Mo.	Day	Yr.	
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6-18 mo.				
		4	4-6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15-18 mo.				
		5	4-6 yrs.				
Tdap		1	11-18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
M-M-R		1	12-15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox date of disease		1	12-18 mo.				
		2					
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian or Physician \_\_\_\_\_

Date \_\_\_\_\_