The Heights
4512 Sherwood Way
San Angelo, TX 76901
325/224-8222

Mother's Day Out

Enrollment Form

Child's Name_____ **Sex**_____ **Date of Birth**_____

Home Address_____ **Age** _____

City_____ **State**_____ **Zip**_____**E-mail**_____

Mother's Name_____ **Mother's Address**_____

Home Phone_____ **Cell**_____ **Work**_____

Father's Name_____ **Father's Address**_____

Home Phone_____ **Cell**_____ **Work**_____

EMERGENCY CONTACT PERSON: In the event that either parent cannot be contacted or cannot pick up their child, these persons can act on the parent's behalf and are authorized to pick up at The Heights. **(All information must be included.)** Children will only be released to a parent or person designated by the parent after verification of I.D.

Name	Address, City, State & Zip	Phone Number
1.		
2.		

CHECK ALL THAT APPLY:

1._____ **Field Trips: I give consent for my child to participate in Field Trips and to be transported by MDO employees.**

2. _____ **VIDEO/PHOTO RELEASE: I give consent for photographs and/or video to be taken of my child while at Mother's Day Out.**

3. _____ **RECEIPT OF WRITTEN OPERATIONAL POLICIES: I acknowledge receipt of operational policies including those for discipline and guidance.**

Signature of Parent:_____ **Date:**_____

For office use only: **Class Enrolled:**_____

Date of Admission:_____

Date of Withdrawal:_____

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Health Requirements Form

HEALTH STATEMENT: (Check only one option)

(____) **1. Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.**

_____ _____
Health Professional's Signature **Date**

(____) **2. A signed and dated copy of a health care professional's statement is attached.**

(____) **3. Medical diagnosis and treatment conflict with the tenants and practices of a recognized religious organization which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.**

(____) **4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 6 months of admission, I will obtain a health care professional's signed statement and will submit it to the Mother's Day Out director at The Heights.**

IMMUNIZATION RECORD: (Check one)

(____) **1. I have attached a copy of my child's most current Immunization Record.**

(____) **2. I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years.**

For additional information regarding immunization, contact the Department of State Health Services at:
http://www.dhs.state.tx.us/immunize/school_info.html

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Medical Treatment Form

Name of Child:_____ **DOB:**_____

I, _____, give The Heights permission to obtain emergency medical treatment for my child. If the physician listed below cannot be reached, permission is granted for another licensed physician to be called.

Child's Physician_____ **Physician's Phone**_____

Address_____

Hospital Preference_____ **Address & Phone**_____

Name of Insurance_____ **Address**_____

Policy Number_____ **Group Number** _____

Allergies & Medical Needs

Allergies:_____

List any special needs:_____

_____

_____

_____

Signature of Parent:_____ **Date:**_____