GRACE GARDEN CHRISTIAN PRESCHOOL

10841 S. 48th Street • Phoenix, AZ 85044 • 480-598-5600
Fax 480-598-5640 • www.gracegardenchristianpreschool.com

APPLICATION FORM

GTF #_________ GTP#_________ GF #_________ GP #_________ GI #_________ GS#_________

Child's Name:			Birthday: / /
(last) (first) (middle)			Sex: M F
Child's Address:			Home phone:
Mother's Name:			Mother • Age:
Home Address:			Home phone:
Occupation:			Cell phone:
Employer:		Work Phone:	
Mom's E-mail Address:			
Father's Name:			Father • Age:
Home Address:			Home phone:
Occupation:			Cell phone:
Employer:		Work phone:	
Dad's E-mail Address:			
Does your child speak English?	Yes ___	No ___	Some ___
What language is spoken at home?	English ___	Spanish ___	Other ___
Do your child have a special need?	Language ___	Physical ___	Emotions ___
Please give the name and address of the school your child last attended:			
How did you learn about our school ?__Newspaper__Relatives___Friends___Walk-in___Internet ___Other			
Number of days per week requested: ______ Full day:_____ Half day: _____			

Registration fee: $____________________ Deposit: $________________

I certify that the above information is correct. Further, I will inform the center of any changes in the above information within 24 hours.

Parent's signature:________________________ Date: ______________

Receive by: ___________________________ Date:______________

Remarks:__________________________ Start Date:______________

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ADMISSION AGREEMENT

I, ________________________________ (parent's name) have read and fully understand my child, ______________________'s (child's name) enrollment package including the parent handbook and agree to abide by the policies started therein. Furthermore, I acknowledge that for the welfare of my child, I am responsible to report any health problem my child may have as well as any special care or treatment needed in case my child becomes ill while at school.

______________________________ ______________________________

Director's Signature Parent's Signature

______________________________ ______________________________

Date Date

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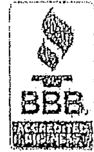

DEPOSIT AGREEMENT

I agree to pay a deposit of ______________ which will be refunded to me upon withdraw of my child from the school, providing I notify the school two week in advance in written form. I understand that without the two week notification the deposit is not refundable.

Child's name ____________________________ no.____________

Parent's signature____

Date________________________________

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FINANCIAL AGREEMENT

I agree to pay a two-week tuition of $__________ in advance on **the first day of every 2 weeks or a monthly tuition of $__________ at the beginning of the month. I understand that after a 3 day grace period a late fee of $5.00 per day will apply to my account.**

Upon registration, there will be a $__________ registration fee. I understand that there is no tuition deduction for absence. For our kindergartner, there is a $__________ books and materials fee. If I withdraw my child during school year, I can keep the books and materials I paid for.

I understand that it is very common for anyone, especially young children to be affected by a new environment. It takes time for the immune system to get accustomed to the germs/bacteria it has not encountered previously. Therefore, there will be no tuition refund because my child has become ill (cold, runny nose, sneezing, coughing, fever, chicken pox, German measles and other communicable diseases) while attending the school.

I also agree to notify the school **2 weeks in advance in written form** before withdrawal.. I understand that **without the 2 weeks notification**, I will not receive the deposit I submitted upon enrollment.

We have provided a **"Tuition Express Form"** for your convenience. Please see the next page to fill out the form and return to the office.

Child's Name ____. No____________

Parent's Signature ______________________________ Date______________

(SEE TUITION & FEE SCHEDULE)

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STUDENT MEDICAL RELEASE/EMERGENCY INFORMATION FORM

I, the undersigned, give my consent to Grace Garden to administer first aid, to authorize a medical doctor to examine my child, to authorize necessary emergency treatment at a nearby hospital and/or to order ambulance transportation for my child at my expense while he or she is in attendance at Grace Garden and or at a related field activity.

Name of Child: ______________________ Date of Birth: ____________

Address: ______________________ City: ____________

State: __________ Zip: __________ Phone: ____-____-____

Insured By: ______________________ ID Number: ____________

In case of emergency-First Contact

First Contact

______________________ Home #: ____-____-____ Work#: ____-____-____

Second Contact

______________________ Home#: ____-____-____ Work# ____-____-____

If we are unable to contact parents please contact:

______________________ Home#: ____-____-____ Work# ____-____-____

Address: ______________________ Relationship: ____________

If we need to contact child's physician:

Child's Doctor: ______________________ Phone#: ____________

Hospital Name: ______________________ Address: ____________

If we are unable to contact child's physician, contact (check one):

Emergency Hospital __________ Nearest Physician: __________ Other: __________

Child's Allergies: ____

____
Signature of Parent of Guardian

____
Date Signed

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PERMISSION FORM

I hereby give my permission for ______________________ (child's name) to be delivered and picked up the following persons.

Signature: ______________________________

I give my permission to have ______________________'s (child's name)

picture taken to be used for educational purposes, (e.g. teacher training or school use)

I understand that my child's name will not be used without my express permission.

Yes : ________ No : ________

I give my permission for my name, address, and telephone number to be given to other parents as business referral.

Yes :________ No: ________

________________________ ________________________

Signature of parent Date

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CDC/SGH# or name: 11059

Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: ☐ male ☐ female

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Parent or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):______________

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to: www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	☐ **No** ☐ **Yes**
Is child usually susceptible to infections and if so, what precautions need to be taken? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Is child subject to convulsions and what should be our procedure if one occurs? **If yes**, specify procedure:	☐ **No** ☐ **Yes**
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Additional comments:	
Other special instructions:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name:**	**DATE:**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Child Care Administration

BEST OF CARE

This confidential form is to help your child care provider support the growth and development of your child while creating a safe, stable and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH

PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PROVIDER/CENTER NAME

Has your child attended child care in the past? ☐ Yes ☐ No

If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

What did you like most about your child's previous child care setting?

What did you like least?

Other comments:

What is important to you about your child's care?

Who is important to your child?

Does your child prefer to play alone or with other children? ☐ Alone ☐ Other children

Does your child have a favorite toy or comfort object? ☐ Yes ☐ No

If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? ☐ Yes ☐ No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

See reverse for EOE/ADA/LEP/GINA disclosures

CHILD'S NAME

Special things you say or do to comfort your child are?

How do you know when your child is:
Happy?
Sad?
Mad?
Tired?
Other?

How does your child react when:
Something unexpected happens?

Something happens he/she doesn't like?

He/She is scared?

Other?

Does your child have any health issues? ☐ Yes ☐ No
If yes, please explain:

Does your child have any other special needs? ☐ Yes ☐ No
If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? ☐ Yes ☐ No
If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

☐ Parent/Guardian declined to complete

Parent/Guardian Signature | Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) ______________________________ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ____________________ Phone # ____________

Cardholder Address ____________________ City ____________ State ____ Zip ____

Account Number ____________________ Expiration Date ____________

Cardholder Signature ____________________ Date ____________

SECTION B (Bank Account)

Your Name ____________________ Phone # ____________

Address ____________________ City ____________ State ____ Zip ____

Bank or Credit Union Name ____________ Bank or Credit Union Address ____________ City ____________ State ____ Zip ____

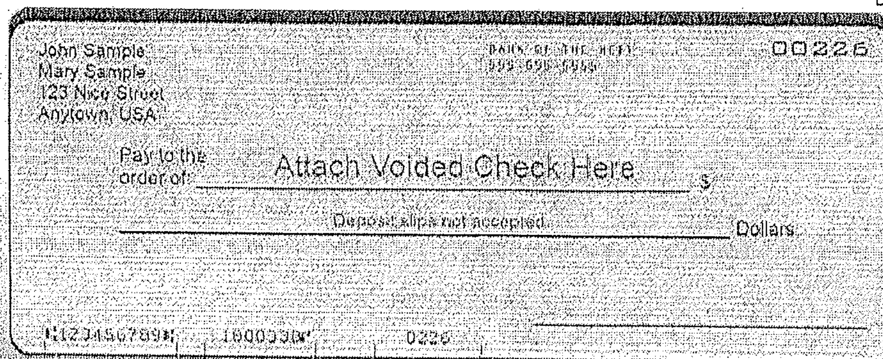
Routing Transit Number (see sample below) ____________ Account Number (see sample below) ____________ ☐ Checking ☐ Savings

Authorized Signature ____________________ Date ____________

For Official Use Only

Date Received ____________

Employee Signature ____________



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