

TRINITY-FIRST WEEKDAY MINISTRIES

801 N. Mesa, El Paso, TX 79902 915-533-2674 Fax 915-533-2690

ENROLLMENT INFORMATION

Documents Completed
 Physicians Statement ____
 Current Immunization Record ____
 Child Profile ____
 TB Questionnaire ____
 Family Handbook pg.10 ____

Please Print

Facility Name: Trinity-First Weekday School		Director's Name: Leticia Ruvalcaba	
Child's Name		Date of Birth	Child's Home Phone
Child's Address			
Date of Admission		Hours and days child will be in care:	
Parent's or Guardian's Names TXDL #		Address (if different from child's)	Parent's E-mail Address
List telephone numbers where parents/guardian may be reached while child is in care:	Mother's Phone No.	Father's Phone No.	Guardian's Phone No.
	Home:	Home:	Home:
	Work:	Work:	Work:
	Cell:	Cell:	Cell:
List a person to call in case of an emergency if parent or guardian cannot be reached: (<i>This person may have access to my child's health information.</i>)	1 Name:	2 Name:	3 Name:
	Phone:	Phone:	Phone:
	Address:	Address:	Address:
	Relationship	Relationship	Relationship
I hereby authorize the day care facility to allow my child to leave the facility ONLY with the following persons:	Name:	Name:	Name:
	Phone:	Phone:	Phone:
I hereby ____ GIVE ____ do not give - my consent for my child to participate in field trips with advance notice. (N/A for Toddlers or Twos)			
I hereby ____ GIVE ____ do not give - my consent for my child to be photographed for T.V., newspapers			
Photos for Child Assessment Documentation Circle (Y) (N) Photo Yearbooks Circle (Y) (N)			
Allowed to apply if needed: Neosporin? (Y) (N) Hand Sanitizer? (Y) (N) Sun Screen? (Y) (N)			
Signature - Parent or Legal Guardian _____			
List any special needs or problems your child may have, including known allergies, existing illnesses, previous serious illness and injuries, any disabilities, any hospitalizations during the past 12 months, and any medication prescribed for long-term use and any other information which staff should be aware of:			

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician Address Phone

Hospital Address Phone

I give my consent for this facility to secure any and all necessary emergency medical care for my child. It is understood that the school or its representatives do not assume any financial responsibility for any expenses that might be incurred for said emergency treatment. It is further understood that school authorities will notify us as soon as possible following the emergency, but in no way is treatment to be delayed until we have been notified. *My health insurance information copied on the back of this form.*

Signature - Parent or Legal Guardian _____