TRINITY-FIRST WEEKDAY SCHOOL MINISTRIES

801 N. Mesa, EI Paso, TX 79902 / 915-533-2674 ext. 23 Fax 915-533-2690

Physicians Statement ____
Current Immunization Record ____
Child Profile ____
TB Questionnaire ____
Family Handbook last page ____

Please Print

ENROLLMENT INFORMATION

Facility Name: **Trinity-First Weekday School**		Director's Name: ***Leticia Ruvalcaba***	
Child's Name:		Date of Birth:	
Child's Address:		Zip Code:	
Date of Admission:		Days Enrolled (M,TU,W,TH,FRI):	
Address (**if different from child's**):			
Persons Legally Responsible:	TX DL # SS#		
List telephone numbers where parents/guardian may be reached while child is in care: Permission to Text: (Y)◉ (N)○ Mobile Carrier: _____	Mother: Cell: Work: E-mail:	Father: Cell: Work: E-mail:	Guardian: Cell: Work: E-mail:
List a person to call in case of an **emergency** if parent or guardian cannot be reached: *(This person may also have access to my child's health information.)*	**1** Name: Phone: Address: Relationship:	**2** Name: Phone: Address: Relationship:	**3** Name: Phone: Address: Relationship:
In addition to the above; I hereby authorize Trinity-First to allow my child to leave the facility with the following persons:	**4** Name: Phone:	**5** Name: Phone:	**6** Name: 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 marketing, advertising, Facebook, social media, television, etc.

Please select- Photos for Assessment/ Internal Postings? (Y)○ (N)◉ Yearbooks? (Y)○ (N)◉

Apply if needed: Neosporin? (Y)○ (N)◉ Hand Sanitizer? (Y)○ (N)◉ Sun Screen? (Y)○ (N)○

Insect Repellant containing DEET? (Y)○ (N)○ Arnica Ointment? (Y)◉ (N)○

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:

Physician	Address	Phone
Dental Emergency	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.***

I have received a copy of the Family Handbook. I agree to abide by all such policies and procedures as defined within.
All above is accurate and agreed upon.

Signature - Parent or Legal Guardian _____ Director_____