BUILDING BLOCKS
PRESCHOOL
at Good Shepherd Lutheran Church

2017-2018 REGISTRATION FORM

****PLEASE WRITE LEGIBLY****

Child's Name _____

Child's Birth Date _____

Sibling Names/Ages

_____

_____

_____

Church Where Baptized / Dedicated

	Yes	No
Food Allergies:	___	___
Asthma:	___	___
Medical:	___	___

(If you answered yes to either of these questions, please explain.)

_____

_____

_____

Mother's Contact Information:

_____
Mother's Name

Mother's Address:

_____

_____

_____

Home: _____
Work: _____
Cell: _____
Occupation: _____
E-mail: _____
Religious Preference: _____
Member of what Congregation: _____

Father's Contact Information

_____
Father's Name

Father's Address:

_____

_____

_____

Home: _____
Work: _____
Cell: _____
Occupation: _____
E-mail: _____
Religious Preference: _____
Member of what Congregation: _____

In what school district do you reside? _____

Who would you like included on school e-mails?
Only Mother: ___ Only Father: ___ Both: ___ Other: ___ Email: _____
Relationship to Child: _____

Emergency Contact Information

Name: _____ Relationship to Child (not a parent): _____
Home: _____ Work: _____
Cell: _____

Please complete back of form and submit non-refundable fees to reserve a place in the Building Blocks Preschool program for the 2017-2018 school year. We reserve the right to change or reconfigure classes according to enrollment.

2017-2018 Building Blocks Preschool

8:45am - 11:45am

Check Class Preference:

Monthly Tuition Rate

Preschool One (1 year by 8/1/17)

_____ 2 days: Tuesday & Thursday	$195 per month
_____ 2 days: Monday & Wednesday	$195 per month
_____ 3 days: Monday, Wednesday, Friday	$265 per month
_____ 4 days: Monday - Thursday	$350 per month
_____ 5 days: Monday - Friday	$430 per month

Preschool Two (2 years old by 8/1/17)

_____ 2 days: Tuesday & Thursday	$195 per month
_____ 2 days: Monday & Wednesday	$195 per month
_____ 3 days: Monday, Wednesday, Friday	$265 per month
_____ 4 days: Monday - Thursday	$350 per month
_____ 5 days: Monday - Friday	$430 per month

Preschool Three (3 years old by 8/1/17 and potty-trained)

_____ 2 days: Tuesday & Thursday	$185 per month
_____ 3 days: Monday, Wednesday & Friday	$240 per month
_____ 4 days: Monday - Thursday	$295 per month
_____ 5 days: Monday - Friday	$365 per month

Preschool Four (4 years old by 8/1/17 and potty-trained)

_____ 3 days: Monday, Wednesday & Friday	$240 per month
_____ 4 days: Monday - Thursday	$295 per month
_____ 5 days: Monday - Friday	$365 per month

Lunch Bunch (available to all students)

11:45 am – 1:30pm

What days would you like to enroll for Lunch Bunch?

$ 9.00 per use & paid monthly

___ Mondays
___ Tuesdays
___ Wednesdays
___ Thursdays
___ Fridays

For Office Use Only

Checks can be made payable to: **Good Shepherd Building Blocks**
All fees are **non-refundable**. One check can be written to cover all fees.

Registration Fee: $90 per year ($80 for each additional sibling.)

Amount received: _____
Date received: _____

Snack Fee: $35 per year ($45 per year for 4 and 5-day students.)

Amount received: _____
Date received: _____

Total Check Amount: _____
Check Number: _____
Check Date: _____

Cash Amount: _____
Received by: _____
Receipt Date: _____

Good Shepherd Lutheran Church
Emergency Consent Form

Name: _____

Address: _____

This Emergency Consent Form will be used as authorization for treatment if a parent or guardian cannot be reached or cannot be with a child when urgent care is needed.

The undersigned, being the parent or legal guardian of _____ do hereby grant permission to obtain any and all urgent medical care and treatment for our child. This authorization includes admission to a hospital or medical care facility if, at the time of injury or illness in my absence, a physician determines such hospitalization is necessary. The undersigned hereby expressly agrees to pay all charges on behalf of our child.

Mother's Signature: _____ Date: _____
Mother's Place of Employment: _____
Mother's Business Phone: _____ Mother's Home Phone: _____
Mother's Cell Phone Number: _____

Father's Signature: _____ Date: _____
Father's Place of Employment: _____
Father's Business Phone: _____ Father's Home Phone: _____
Father's Cell Phone Number: _____

Medical Information – Please provide the following information so medical staff can treat your child, complete medical records, and initiate your insurance claims.

Child's Date of Birth: _____ Sex: _____

Allergies: _____

_____

Special Medical Conditions: _____
_____
(include other inoculations, medications, major illness, hospitalizations, etc.)

THE FOLLOWING INFORMATION IS NEEDED:

Name of Child's Physician: _____
Physician's Phone Number: _____
Insurance Company: _____
Emergency Contact Person: _____
Relationship to the Student: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

MISSOURI IMMUNIZATIONS NOTICE

In accordance with Section 210.003.7, RSMO, the parent or guardian of a child enrolled in or attending Building Blocks Preschool may request notice of whether there are any children enrolled at our facility with and immunization exemption on file. If you would like to request this information, please contact Kathy Rebholz at Building Blocks Preschool and the information will be provided to you. Please note, the name or names of individual children are confidential and will not be released. Our response will be limited to whether or not there are children enrolled at our facility with an immunization exemption on file.

I have been notified that I may request notice at initial enrollment or any time there after whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.

Parent Signature: _____

PHOTO AND BUZZ BOOK AGREEMENT FORM

I ☐do ☐do not allow Building Blocks Preschool to release directory information (name, address, phone, email, etc.) concerning my child in the Preschool Buzz Book.

I ☐do ☐ do not allow my child's photo to be printed and displayed (on bulletin boards within the Building Blocks Preschool and shared among other Building Block's families in my child's class.

I ☐do ☐do not allow my child's photo (not name) to be published through various digital platforms (end-of-year slideshow, website, and or Building Blocks Brochure)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____
DAY CARE PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS		
A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

HEALTH REPORT FOR SCHOOL-AGE CHILD
CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

☐ MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

☐ MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS

ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS

PARENT/GUARDIAN SIGNATURE	DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

IMMUNIZATION CONSENT AND HISTORY

CLINIC IDENTIFICATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX
				☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	#ZIP CODE	PHONE

RACE (select all that apply)
☐ Amer Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American

ETHNICITY
☐ Hispanic or Latino
☐ Non Hispanic or Latino

PARENT/GUARDIAN FULL NAME

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Vaccine and Route (circle type given where pplicable)	Visit # and M/D/Y Given	Injection Site	Vaccine Manufacturer/ Lot Number	Vaccine Exp. Date	VIS Revision Date	Date VIS Given	Signature of Vaccinator	Patient or Parent/Guardian Consent
Hepatitis B Hep B IM								**Visit # 1** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Diphtheria, Tetanus, Pertussis DTaP DTP DT IM								**Visit # 2** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Haemophilus influenzae type b Hib IM								**Visit # 3** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Polio Polio SQ IM								
Pneumococcal conjugate PCV 7 IM PCV 13 IM								**Visit # 4** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**

Comments

IMMUNIZATION CONSENT AND HISTORY *(continued)*

PATIENT NAME

Vaccine and Route (circle type given where applicable)	Visit # and M/D/Y Given	Injection Site	Vaccine Manufacturer/ Lot Number	Vaccine Exp. Date	VIS Revision Date	Date VIS Given	Signature of Vaccinator	Patient or Parent/Guardian Consent
Pneumococcal polysaccharide PPSV 23 SQ IM								**Visit # 5** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Measles, Mumps, Rubella MMR SQ								
Varicella Varicella SQ								
Rotavirus RV1 Oral RV5 Oral								**Visit # 6** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Hepatitis A Hep A IM								
Human papilloma-virus HPV2 IM HPV4 IM								**Visit # 7** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Meningococcal MCV4 IM MPSV4 SC								**Visit # 8** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Tetanus, Diphtheria, Pertussis (7years old and above) Tdap IM Td IM								
Influenza TIV (inactivated) IM LAIV (live attenuated) Intranasal IN								**Visit # 9** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Other								**Visit # 10** Date Signature: **Eligibility Status:** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Other								
Other								
Other								

Comments