



**CHILD'S NAME:** \_\_\_\_\_

521 32<sup>nd</sup> Ave W. West Fargo, ND 58078  
 Office: 701.356.3939 Fax: 701.356.3940  
 www.beginningschildcarecenter.com

**PRESCHOOL REGISTRATION: 2018-2019**

September , 2018 - May 24, 2019

TO REGISTER, PLEASE SUBMIT THE FOLLOWING:

**\*\*All is required TO GUARANTEE YOUR SPOT**

- Completed registration packet
  - Student Information
  - Medical Information
  - Emergency Medical Care
  - Child Release
  - Student Transportation Form *(if applicable)*
  - Photo permission Form
  - Acknowledgment of parent handbook
  - Tuition Express Form **\*\**(for new families only)***
  - Parent Statement of Health
- \$65 non-refundable registration fee
- First month's tuition
- Transportation fee *(if applicable)*
- Up to date immunization record
- Copy of Birth Certificate
- Medication Authorization *(if applicable)*

*\*All deposits and fees will be debited from your Tuition Express account. No checks, please.*

*\*\*Deposits & fees will be deducted from your account the Friday following submission of this form.*

Questions may be directed to Beginnings Preschool at 701.356.3939 OR emailed to [brandi@beginningschildcenter.com](mailto:brandi@beginningschildcenter.com).

**OFFICE USE ONLY:**

Date registration received: _____	Paperwork eFiled on _____ by _____	Assigned classroom: _____
Registration fee received? Y/N	<input type="checkbox"/> Charged Tuition Express on: _____ <input type="checkbox"/> Pmt: _____	Immunization record received? Y/N
First month's tuition received? Y/N	<input type="checkbox"/> Charged Tuition Express on: _____ <input type="checkbox"/> Pmt: _____	Birth certificate viewed? Y/N
Transportation fee received? Y/N	<input type="checkbox"/> Charged Tuition Express on: _____ <input type="checkbox"/> Pmt: _____	

## CLASS OPTIONS, REQUIREMENTS, & TUITION

Please indicate your first (1) and second (2) preferences.

All classes are subject to community need. Three year olds must turn 3 by August 1, 2015. Four year olds must turn 4 by August 1, 2015.

✓	CLASS OPTIONS	TIME	REQUIREMENTS	TUITION
	2 day morning -Tues. & Thurs.	8:20-11:05 am	3 YEAR OLDS -Must be fully potty trained	<b>PRESCHOOL ONLY :</b> \$230/month <b>ENROLLED IN CHILDCARE:</b> \$200/month
	3 day morning -Mon/Wed/Fri	8:20-11:05 am	3 & 4 YEAR OLDS -Must be fully potty trained	<b>PRESCHOOL ONLY :</b> \$270/month <b>ENROLLED IN CHILDCARE:</b> \$240/month
	3 day afternoon -Mon/Wed/Fri	12:15- 3:00 pm	3 & 4 YEAR OLDS -Must be fully potty trained	<b>PRESCHOOL ONLY :</b> \$270/month <b>ENROLLED IN CHILDCARE:</b> \$240/month
	5 day morning - Mon. - Fri.	8:20-11:05am	4 & 5 YEAR OLDS -Must be fully potty trained -Must be entering Kindergarten the following year.	<b>PRESCHOOL ONLY :</b> \$330/month <b>ENROLLED IN CHILDCARE:</b> \$300/month
	5 day afternoon -Mon. - Fri.	12:15-3:00 pm	4 & 5 YEAR OLDS  -Must be fully potty trained -Must be entering Kindergarten the following year.	<b>PRESCHOOL ONLY :</b> \$330/month <b>ENROLLED IN CHILDCARE:</b> \$300/month

### REGISTRATION FEE: \$65

This annual fee will cover school supplies, art supplies and improvements to the technologies we use in the classrooms.

### PAYMENT OPTIONS

Tuition will be automatically withdrawn via Tuition Express. Families have the following options for tuition - please indicate your preference.

- Monthly: Tuition will be withdrawn the 1st of each month. If the 1st falls on a holiday or weekend, it will be taken out the next business day.
- Bi-weekly: Tuition will be withdrawn bi-weekly on Fridays *the month prior*.

## **STUDENT INFORMATION**

*\*Please provide as much information as possible. Do NOT assume any information is known.*

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER: M F ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

MOTHER'S EMAIL: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

FATHER'S EMAIL: \_\_\_\_\_

Who else lives in the home (siblings, extended family members, pets)? \_\_\_\_\_

What topics interest your child? \_\_\_\_\_

Has your child attended a daycare or preschool in past years? \_\_\_\_\_

For how long? \_\_\_\_\_

Do you have any special concerns about your child (academically, socially, medically, etc.)? \_\_\_\_\_

Please list any foods, stings, etc. that may cause allergic reactions with your child. \_\_\_\_\_

What would you like to see your child gain from their experience in school this year? \_\_\_\_\_

Is there anything you would like your child's teacher to know? \_\_\_\_\_

## MEDICAL INFORMATION

\*Please provide as much information as possible. Do NOT assume any information is known.

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Sex: M / F  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_  
Identifying Marks: \_\_\_\_\_  
Identified Allergies: \_\_\_\_\_  
Special Needs or Program Adaptations: \_\_\_\_\_  
Health Insurance Provider: \_\_\_\_\_  
Name of Physician/Clinic: \_\_\_\_\_

## EMERGENCY MEDICAL CARE

Every effort will be made to contact me in the event of an emergency requiring medical attention for my child, \_\_\_\_\_. If I cannot be reached, the emergency contacts will be called. I authorize Beginnings to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. Staff is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In a center, any member of the staff responsible for the care and education of my child may view my child's health information, as well as state licensors and health care consultants for compliance purposes.

Child's Health Insurance Provider \_\_\_\_\_

Name of insured \_\_\_\_\_ Policy # \_\_\_\_\_

## CHILD RELEASE

For children's safety, Beginnings will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below by the parent/guardian. Beginnings will not release my child to any other person unless I notify the center, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form but does not regularly pick up my child or has never before picked up my child, I will notify the center verbally, in advance.
- If the person picking up my child is NOT listed on this form, I must notify the center in writing, in advance.
- Photo identification will be required of any person picking up my child.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_

## PHOTO PERMISSION FORM

During the school year, we like to take pictures and video of the class as they help preserve to memories of the school year.

Pictures will be taken as we do special projects, go on field trips, or go about our daily routine. The photos taken will be used for classroom publications (newsletter, yearbook, Seesaw) and arts & crafts projects. In the past we have had articles published in *The Forum* and the *Pioneer* newspapers! Students and parents in the past have enjoyed seeing their child in Seesaw posts, crafts, etc. - it certainly makes the students feel special!

Please take a quick moment to fill out the following.  
Thank You!

\_\_\_\_\_ Yes, I give my permission for my child to be photographed or videoed during activities at school or on field trips. The images may be used in classroom publications, the local newspaper, television, or the Internet.

\_\_\_\_\_ No, I prefer that my child not be photographed at school or on field trips. I understand that my child's image will not be included in our scrapbook, yearbook or in the class newsletter.

Child's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACKNOWLEDGEMENT OF PARENT HANDBOOK

I agree to read through the Beginnings Preschool Parent Handbook (located at [www.beginningschildcare.com](http://www.beginningschildcare.com) in the Preschool Tab) and to refer to and abide by the policies and procedures stated within throughout the school year.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_



## **TRANSPORTATION REGISTRATION FORM: 2018-2019**

Beginnings Preschool will do everything we can to accommodate transportation requests. We transport students within a 5 mile radius of Beginnings. This registration is not a guarantee of transportation services.

### **TRANSPORTATION FEES**

2 DAY: \$20/month • 3 DAY: \$25/month • 5 DAY: \$30/month

### **STUDENT INFORMATION**

CHILD'S NAME: \_\_\_\_\_

CLASS SESSION : •AM or PM      •2 DAY •3 DAY •5 DAY

LOCATION: •HOME • DAYCARE

PARENTS' NAMES:

\_\_\_\_\_

PARENTS' PHONE : \_\_\_\_\_

DAYCARE PROVIDER'S NAME: \_\_\_\_\_

PARENTS' PHONE : \_\_\_\_\_

### **ADDRESS TO BE TRANSPORTED TO AND FROM:**

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

### **ADDITIONAL NOTES**

Is there anything you would like the bus driver to know??

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS  
SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility.  
This form is completed by a parent or guardian of the child.

Full Legal Name of Child:		Birth Date:	Enrollment Date:	Please check one: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Dropin <input type="checkbox"/> B/A School	
Full Legal Name(s) of Parent or Guardian:				Relationship:	
Address:			City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:			
Family Physician:		Clinic:	Telephone Number:		
Hospital:				Telephone Number:	
Last Visit to Doctor:		Child's Height:	Child's Weight:		
Does The Child Have Any food, medication or environmental allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, List Allergies:		Describe Allergy Reaction:		Usual Treatment:	
Please Check If Any Of The Following Conditions Exist:					
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Behavioral Issues		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Frequent Earaches	<input type="checkbox"/> Other Conditions (please specify):		
<input type="checkbox"/> Vision Impairment	_____				
Please Explain All Checked Items:					
Is The Child Under Current Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:					
Are There Any Medications That The Child Takes Daily? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:					
Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:					
Is there a health care plan for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach					

**INSURANCE:**  
Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

**CERTIFICATION:**  
I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature:	Date:
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## Authorization for Non-Prescription Medications

Form provided by Health Consultant Team at Child Care Aware® of North Dakota

Written parental permission is required by licensing for administration of over-the-counter (OTC) medications. To reduce the likelihood of a parent lawsuit, it is recommended that child care providers also obtain written instructions and permission from a health care provider.

OTC medications should be kept in the original manufacturer's container. The medication should be labeled with the child's name by the parent, and given according to the manufacturer's instructions. Make sure the medication is not expired.

- Cold and cough medication is not recommended for children under 6 years old.

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Use one form for each medication. Please fill out completely and print clearly.

Name of child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time(s) of day medication is to be given: \_\_\_\_\_

Special instruction (ie: refrigerate): \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Time of last dose (if applicable): \_\_\_\_\_

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Program/Provider's name: Beginnings Child Care Center & Preschool, INC.

Parent(s) or guardian(s) name (printed): \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare provider's name: (printed): \_\_\_\_\_

Signature of health care provider: \_\_\_\_\_ Date: \_\_\_\_\_

Date	Time Given	Dose	Signature

Keep this form in the child's file when medication is finished.





# Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

## ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** AUTHORIZATION

I (we) hereby authorize Beginnings Child Care Center (business name) to initiate debit entries to my (our) Checking or Savings Account indicated below. 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.

Your Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Bank or Credit Union Name \_\_\_\_\_

Bank or Credit Union Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Checking  Savings

Routing Transit Number (see sample below) \_\_\_\_\_ Account Number (see sample below) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Check if you wish to make online payments

**For Official Use Only**

Date Received

Employee Signature



A service of



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SOFTWARE®