CHILD'S NAME:______________________

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

PRESCHOOL REGISTRATION:

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.

OFFICE USE ONLY:

Date registration received: ________________	Paperwork eFiled on ________________ by ______________________________	Assigned classroom: ______________________
Registration fee received? Y/N	☐ Charged Tuition Express on: _________ ☐ Pmt:________________	Immunization record received? Y/N
First month's tuition received? Y/N	☐ Charged Tuition Express on: _________ ☐ Pmt:________________	Birth certificate viewed? Y/N
Transportation fee received? Y/N	☐ Charged Tuition Express on: _________ ☐ Pmt:________________	

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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	**PRESCHOOL ONLY :** $230/month **ENROLLED IN CHILDCARE:** $200/month
	3 day morning -Mon/Wed/Fri	8:20-11:05 am	3 & 4 YEAR OLDS -Must be fully potty trained	**PRESCHOOL ONLY :** $270/month **ENROLLED IN CHILDCARE:** $240/month
	3 day afternoon -Mon/Wed/Fri	12:15- 3:00 pm	3 & 4 YEAR OLDS -Must be fully potty trained	**PRESCHOOL ONLY :** $270/month **ENROLLED IN CHILDCARE:** $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.	**PRESCHOOL ONLY :** $330/month **ENROLLED IN CHILDCARE:** $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.	**PRESCHOOL ONLY :** $330/month **ENROLLED IN CHILDCARE:** $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*.

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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 attened 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? __________
____
____

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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____

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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 T*he 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 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: $40/month • 3 DAY: $65/month • 5 DAY: $90/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: ☐ FT ☐ PT ☐ Dropin ☐ 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: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues
☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): ______
☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ 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? ☐ Yes ☐ 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

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.

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): ______________________

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.

Revised 7/15

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 ____________________

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