



# **Samish Early Learning Center**

## **Application**

**Hours of Operation: Mon-Fri 7:30am-5:30pm**

Registration fee: \$50.00 (first child) \$30.00 (additional children)  
Current Rates: Attached

In order to process your attached application we will need the following documents:

- Child's Birth Certificate**
- Child's Immunizations or Certificate of Exemption**

Upon registration, you will receive our Parent Handbook and required Agreement Forms. These agreement forms will need to be signed and submitted before attendance.

**Thank you! Please feel free to contact us with any questions!**



# Samish ELC Enrollment Form

Please circle requested days of care:

Mon Tu Wed Th Fri

Times: \_\_\_\_\_ to \_\_\_\_\_

Child Information					
Name (Last, First, MI)		DOB	Gender	Language(s) spoken:	
			<input type="checkbox"/> M <input type="checkbox"/> F	Primary:	Secondary:
<b>Parent or Guardian</b> - All parents/guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.					
Relationship to Child	Name	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.
<b>Authorized Persons</b> - Persons other than parents/guardians who are authorized to pick up the child. If no one, write "None".					
Relationship to Child	Name	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.
<b>Emergency Contact</b> - The person to be notified in an emergency when parents/guardians cannot be reached					
Relationship to Child	Name	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.
This person is authorized to pick up the child <input type="checkbox"/> Y <input type="checkbox"/> N					
This person is authorized to pick up the child <input type="checkbox"/> Y <input type="checkbox"/> N					

Physician or Medical Facility			
Name	Address (Street, City)	Telephone No.	Date of last exam
			Does your child have a diagnosed disability? <input type="checkbox"/> Y <input type="checkbox"/> N
			if Y, on an IEP/IFSP? <input type="checkbox"/> Y <input type="checkbox"/> N
Dental Provider			
Name	Address (Street, City)	Telephone No.	Date of last exam

Does your child have allergies or reactions to food, medicines, insects, animals, or other substances?

Yes  No

If Yes... if the allergy has the potential to be severe, the child's healthcare provider must complete a medical statement and an allergy care plan must be completed. Your child will need the signed provider's statement BEFORE starting in the classroom.

Please describe your child's allergy, symptoms, and severity: \_\_\_\_\_

Does your child take medication on a regular basis?

Yes  No

If Yes... and the child requires dosage during care hours, you will need to complete our medication authorization form.

Does your child have any life threatening medical conditions that requires an individual health plan?

Yes  No

Do you have any health or developmental concerns regarding your child?

Yes  No Please describe your concerns, if any: \_\_\_\_\_

Yes  No I give permission for my child to receive first aid treatment by qualified staff persons.

Yes  No I give permission for my child to participate in field trips and other activities during operating hours with 24hr notice for transported trips.

Transported  Walking

Yes  No I give permission for my child to be in a class photo or a photo of classroom activities/field trips that may be posted or printed and shared with other families, children, or staff.

Yes  No I give permission for pictures of my child or family to be used by the program for training, newspaper articles, or promotional displays.

Signature - Parent or Guardian

Date Signed