Enrollment Date:_____
Withdraw Date:_____

Little Blessings Child Development Center

Child's Information:

Full Legal Name (*as shown on birth certificate*):

_____ _____ _____
First Name Middle Last Name

Preferred name:_____ Gender: _____ DOB:_____

Ethnicity: _____ Race: _____ Hispanic? _____

Tribal Affiliation: _____ Primary language spoken in the home: _____

Child resides with: _____

Family Information:

Mother / Guardian Name: _____

Address_____ _____ _____ _____
Street City State Zip

SS #: _____-___-_____ Email: _____

Phone #s: Home/Mobile: _____Work: _____

Employer Name: _____Employer Address:_____

Father / Guardian Name: _____

Address_____ _____ _____ _____
Street City State Zip

SS #: _____-___-_____ Email: _____

Phone #s: Home/Mobile: _____Work: _____

Employer Name: _____Employer Address:_____

Local Emergency Contacts – *Not mother or father* - *You must list two*

1. Name: _____ Phone:_____ _____
   Phone:_____ _____ Relation to Child: _____
2. Name: _____ Phone:_____ _____
   Phone:_____ _____ Relation to Child: _____

Others Authorized to pick up your child *(other than emergency contacts)*

Name: _____ Phone:_____ _____
Phone:_____ _____ Relation to Child: _____

Signed:_____ **Date:**_____

Physician's Name:_____ **Phone:**_____

Preferred Hospital: _____ **Phone:**_____

Kindergarten Transition Information

What Elementary School will your child attend for kindergarten?

Look up your child's school in the Albuquerque Public Schools District: https://www.aps.edu/find-my-school/

Look up your child's school in the Moriarty-Edgewood School District: https://www.mesd.us/page/registration

New Mexico PreK Tuition Agreement

- New Mexico PreK is ***FREE*** for PreK Days and Hours ***ONLY***
- Outside PreK Hours are billed at $6.50 per hour.
  - Before 8:45am or after 3:15pm
  - Any "No PreK days" as indicated on our calendar
- **Automatic payments through Tuition Express are required for all families** (as of 4/1/2022)
- Automatic payments may be scheduled on a day other than the 1st or 15th at the discretion of the director.

New Mexico PreK operates Monday through Friday from 9am-3pm
Daily attendance is required to participate in New Mexico PreK
It is ***your responsibility*** to clock your child in and out each day that your child attends!

I have read and agree to follow all policies and procedures of Little Blessings Child Development Center.

Parent/Guardian _____ Date _____

Director Janet Rendon Date _____

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize Little Blessings Child Development Center to initiate credit cardcharges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). 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 numbersfor automatic payments. Check with the center for accepted credit card types.

Process my payment on: ☐ ***Every Monday*** ☐ ***1st of each month*** ☐ ***15th of each month***

COMPLETE ONE SECTION ONLY *(Credit Card or Bank Account)*

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

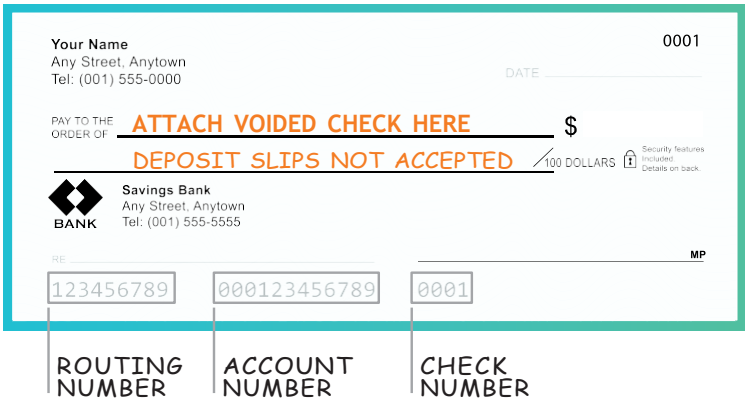
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

800.338.3884 • procaresoftware.com

Health and Developmental Questionnaire

Child's Name: _____DOB: _____

Date of Last:
Well Check: _____ Dental visit: _____
Vision test: _____ Hearing screening: _____

Do you need resources for: Dental Visit? ☐ Vision Test? ☐ Hearing Screening? ☐

Has your child had any of these diseases or complications with (check all that apply):

- ☐ Hepatitis
- ☐ Measles
- ☐ Tuberculosis
- ☐ Fainting Spells
- ☐ Frequent Cold
- ☐ Frequent Sore Throat
- ☐ Lice
- ☐ Urinary problems
- ☐ Stomach Upsets
- ☐ Asthma
- ☐ Bronchitis
- ☐ Diabetes
- ☐ Constipation
- ☐ Convulsions
- ☐ Diarrhea

Please list any illness not listed above:

_____

Please list any known allergies:

_____

Does your child have any special dietary needs? ☐
If dietary needs do not align with CACFP requirements, we must have written instructions from your child's doctor detailing the specific restrictions/modifications.
Please explain:

_____

Does your child function at the level of other children in his/her age group? ☐
Please explain:

_____

Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group setting? ☐
Please explain:

_____

Does your child currently have an IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan)? ☐
If yes, do you agree to provide us with a copy to better support your child's needs? ☐

Parent/Guardian Signature_____ Date _____

ASQ – CONSENT FORM

The Ages & Stages Questionnaires® (ASQ®) are used to screen young children ages 1 month to 6 years to help determine if their development is on schedule—or if further evaluation may be needed. ASQ also helps parents, together with providers, learn more about a child's strengths and areas that may need support.

The first 5 years of life are very important foryour child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in thescreening/monitoring program.

☐ I have read the information provided about the Ages & Stages Questionnaires Third Edition (ASQ-3)and ASQ-SE and I wish to have my child participate in the screening/monitoring program.

☐ I would like to administer the ASQ-3 and/or the ASQ-SE at home with my child.

☐ I do not wish to participate in the screening/monitoring program. I have read the provided informationabout the Ages and Stages Questionnaires, Third Edition (ASQ-3) and understand the purpose of this program.

_____ _____

Parent/Guardian Signature Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, #of weeks premature: ____

Child's primary physician: _____

Enrollment Agreement

Mandated by State Licensing Regulations

I, the parent/guardian of _____, understand the policies and procedures of Little Blessings Child Development Center. I agree to abide by the rules and regulations set forth by the director of this facility. I further understand that this center is licensed and regulated by the State of New Mexico. I understand all costs associated with childcare at this facility and accept responsibility for all charges incurred at Little Blessings Child Development Center.

I have read and agree to follow all policies and procedures of Little Blessings Child Development Center.

Parent/Guardian _____ Date _____

Consent for Emergency First Aide & Transportation

I hereby give permission that my child, _____, may be given emergency treatment by a staff member at Little Blessings Child Development Center. I agree not to hold the director, owner, company, board members, or any staff member responsible for any injury sustained by my child while in the care of this facility. Furthermore, in the event of an emergency, I give permission for my child to be transported to the nearest emergency facility by the most expedient means necessary and that neither staff, nor the director of this facility, nor the company, nor its board members will be held responsible for injuries sustained to my child while in transit.

Parent/Guardian _____ Date _____

Consent for Medical Care and Treatment

In the event that I cannot be contacted immediately, I give permission that any medical treatment deemed necessary by an attending physician may take place. I. again, hold Little Blessings Child Development Center and all its employees NOT liable.

Parent/Guardian _____ Date _____

Photo Release

Little Blessings Child Development Center participates in the New Mexico PreK Program, administered by the New Mexico Early Childhood Education and Care Department (ECECD) and the Public Education Department (PED) along with our Contractor, UNM Continuing Education. These partners ask permission to take photographs and/or to videotape your child during their time in the NM PreK classroom. We are asking your permission to take photographs of or film of your child. Copies may be used by us, ECECD, PED or UNM-CE in ongoing research, reports, marketing materials to promote New Mexico PreK, etc. Pictures/film of your child may be used for training purposes or in future professional publications. For all of the above, we require your permission.

If you do not want your child's photograph taken at all, you have the option of declining. Thank you for your cooperation and support.

The undersigned parent or legal guardian does hereby consent for their child to be photographed or videotaped, and does hereby authorize Little Blessings Child Development Center, the State of New Mexico, or its contractor, UNM- Continuing Education staff to take photographs or videotapes, which will be used for research, training, brochures, reports, marketing, and the like. The undersigned does hereby release Little Blessings, the State of New Mexico or its contractor, UNM-CE staff from any and all claims for damages for libel, slander, invasion of the right of privacy, or any claims based on the use of said material. This includes compensation of any sort now or in the future, in the event that your child's photograph or videotape is used in any of the aforementioned materials including professional publications, marketing, training, reports, etc. developed by NM PreK and their contractor, UNM Continuing Education. Please check the boxes that apply.

☐ I authorize my child to be videotaped and/or photographed and the use of my child's image for publication in reports, professional articles and books, professional development, and promotional/marketing materials.

☐ I ***do not*** want my child to be videotaped or photographed.

I CERTIFY all of the following: This form has been explained to me and/or I have read the contents of this form, or the contents have been read to me. I understand the contents of this form and/or the explanation of the contents of this form. All blanks or statements requiring insertion or completion were filled in and all items not applicable were stricken before I signed.

Parent/Guardian Signature_____ Date _____

Little Blessings Child Development Center
Family Handbook Acknowledgement

I, _____, have read and understand the policies and procedures as specified in the Family Handbook. I further understand that updated Family Handbooks are available online at: http://www.tlcdevelopmentcenters.org/

By signing the Family Handbook Acknowledgement, I agree that I have, as stated above, read, and understand the policies and procedures set out in the Family Handbook.

Parent/Guardian _____ Date _____

General Information and Consent

I have provided Little Blessings Child Development Center with the following documents ***(required PRIOR to first day of attendance):***

- ✓ Income Eligibility Application
- ✓ Up to date Immunization Records
  (to be re-submitted each time a new Immunization is administered)
- ✓ Copy of _____'s Birth Certificate or Hospital Record

and have read information regarding my child's enrollment. I understand that identification may be required before my child is released to unrecognized individuals. I understand that Little Blessings Child Development Center retains the right to disenroll my child if my child's needs are not being met adequately, which is up to the discretion of the center Director. I affirm that all information on the registration form is accurate and true to the best of my knowledge. I am aware that I am welcome at any time to observe my child at Little Blessings Child Development Center, with the understanding that I am to respect the teachers in the rooms and in the confines of the building. I understand that any threatening or belligerent behavior on the part of my child or me may be grounds for immediate disenrollment.

Parent/Guardian _____ Date _____

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ **DATE** _____

NAME OF CHILD LAST FIRST MIDDLE	**AGE**	**GRADE**	**SEX** (CIRCLE ONE) M F	**HEIGHT** INS.	**WEIGHT** LBS.
ADDRESS NO. AND STREET CITY OR POST OFFICE BOROUGH OR TOWNSHIP COUNTY STATE ZIP					

IMMUNIZATION STATUS: (Give Date of Last Booster and Last TB Test)

	Yes	BASIC (Date)	No	BOOSTER (Date)
TRIPLE ANTIGEN (DPT)				
DTAP				
DIPHTHERIA TOXOID				
TETANUS TOXOID				

POLIO VACCINE	ORAL (Date)	SALK (Date)
TYPE I		
TYPE II		
TYPE III		
BOOSTER		

MMR #1_____, #2_____

MEASLES VACCINE Type_____ Date_____

PREVNAR _____

MENACTA _____

HEPATITIS B (DATES) #1_____, #2_____, #3 _____

VARIVAX #1 _____, #2_____

TUBERCULIN TEST – Type _____, Date _____, Result _____

OTHER (SPECIFY) _____

MEDICAL HISTORY: (Give significant details, including serious illness, allergies, operations, accidents, etc.)

REPORT OF EXAMINATION: (Elaborate below on *positive* findings)

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
GENERAL NUTRITION			GLANDS			SKELETON		
SKIN			HEART			POSTURE		
EYES			LUNGS			EMOTIONAL STATUS		
EARS			ABDOMEN			HEARING		
NOSE AND THROAT			GENITALIA (MALE)			SCOLIOSIS (Bending Position)		
TEETH AND GINGIVA			NEURO MUSCULAR SYSTEM					

BLOOD PRESSURE _____

VISION: R 20/ L 20/ + LENS
Wears corrective lens Yes _____ No _____

Is the child under treatment? Yes _____ No _____

Should this child have restrictions on play or physical education activities? Recommendations:

What other recommendations do you wish to make to teacher of school nurse which might be of benefit to this child from the point of view of either physical or mental hygiene?

SIGNATURE OF EXAMINING PHYSICIAN ADDRESS TELEPHONE

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough/Township | County | State | Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address