Child Plus Learning Centre
Day Care and Pre-School
2 FLorida Avenue, Independence City, Gregory Park P.O.
Tele: 988-4888 / 4289962
email: childplus@gmail.com

**EARLY CHILDHOOD DEVELOPMENT CENTRE**
**STUDENT ADMISSION RECORD**
**REGION 6**

REFERENCE NO …… DATE…….……..

NAME OD ECDC……

NAME OF CHILD …… SEX…….....

DATE OF BIRTH…… BIRTH CERTIFICATE NO……

RELIGIOUS AFFILIATION……..……..……

LAST ECDC ATTENED……..……...…..

REASON FOR LEAVING…….

CLASS PLACED ON ADMISSION……..... CLASS ON LEAVING……

NO. OF SIBLINGS…… PLACE IN FAMILY…… PET NAME……

MOTHER'S NAME…….…..PHONE NO……..

ADDRESS……

OCCUPATION……..WORK NO……

FATHER'S NAME……..PHONE NO……

ADDRESS……

OCCUPATION……WORK NO……

GUARDIAN'S NAME…….PHONE NO…….

ADDRESS……

OCCUPATION……..…….…….WORK NO…….…

NAME OF PERSON TO COLLECT CHILD……..

NB (IN CASE OF CHANGE INFORM ECDC IMMEDIATELY)

IN CASE OF AN EMERGENCY, CONTACT……..

ADDRESS……

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SPECIAL DIETARY REQUIREMENT (IF ANY)…….

**MEDICAL INFORMATION**

FAMILY DOCTOR……. PHONE NO……..……

ADDRESS……

HEALTH FACILITY…….

DOES THE CHILD SUUFER FROM ANY OF THE FOLLOWING? (TICK ALL APPROPRITE BOXES)

ASTHMA ☐ SICKLE CELL ☐ DIABETES ☐ EPILEPSY (FITS) ☐

RMELMATIC FEVER/ HEART DISEASE ALLERGIES ☐ ALLERGIES ☐

OTHER (PLEASE SPECIFY) ☐ …….

SPECIAL NOTE……

## IMMUNIZATION RECORD

| | 1ST | 2ND | 3RD | 4TH | 5TH |
|---|---|---|---|---|---|
| BCG | | | | | |
| OPV/IPV | | | | | |
| DT/ DPT | | | | | |
| MMR | | | | | |
| VARICLLA | | | | | |
| HEPATITS B | | | | | |
| HIB | | | | | |
| PENTAVALENT (DPT, HEP B, HIB) | | | | | |
| OTHER | | | | | |

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## ABOUT YOUR CHILD

1. What is your child favorite toy ,game or activity_____
2. Does your child have any particular mannerism such as thumb sucking or nail biting etc _____
3. If "yes" please state_____
4. Does your child have any particular fears such as dogs, lightening, siren, lizard etc _____
5. If "yes" please state_____
6. What method do you use to reward your child's good behavior_____
7. What method do you use to correct your child's negative behavior _____
8. Is your child able eat/ drink y him/herself_____
9. What type of food does your child:

- Like_____
- Dislike_____

10. Is your child toilet trained_____ What word does your child use for toilet_____
11. Does your child usually take naps?_____

- How long _____ how many times per day? _____

12. Any disorders/developmental (slow advance) diagnosed or suspected? _____
13. Anything else you would like to inform the center should be aware of regarding your child?

_____

_____

_____

_____

_____

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# Child Care Provisions and Parents Contract

**General Information:**

***CHILD***

Child's Name: _____

Date of Birth: _____

Weight: _____ Height: _____

***MOTHER***

Mother's Name: _____

Marital Status: Married [ ] Divorce [ ] Single [ ] Widowed [ ]

Home Address: _____

_____

Home Tel. No.: _____

Name of Employer: _____

Occupation: _____

Work Address: _____

Work Telephone No.: _____

***FATHER***

Father's Name: _____

Home Address: (if different from above) _____ _____

_____

Home Tel. No.: _____

Father's Employer: _____

Occupation: _____

Work Address: _____

Work Telephone No.: _____

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***PICKUP INFORMATION:*** (Information on person(s) authorized to pick up your child (ren) from the Centre)

Name: _____

Address: _____

_____

Tel. No.: _____

Employer's Name: _____

Occupation: _____

Work Address:_____ _____

Work Telephone No.: _____

Relationship to child: _____

Name: _____

Address: _____

_____

Tel. No.: _____

Employer's Name: _____

Occupation: _____

Work Address:_____

Work Telephone No.: _____

Relationship to child: _____

**PLEASE NOTE: Under NO circumstances will any child be release to anyone other than those listed above without a written authorization from the parent / guardian.**
**Emergency Procedures;**

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***EMERGENCY CONTACT***

Name of Contact person if Parent (s) cannot be reached: _____

Address: _____

Tel: No._____

Work Address: _____

Tel. No: _____

Name of Physician in case of medical emergency_____

Address: _____

Tele. No: _____

***MEDICAL INFORMATION***

Any allergies: Yes [ ] No [ ] If yes please specify_____

Prescription Medicine taken regularly: _____

Date of Surgery (If any):_____ Blood Type: _____

Handicapping Conditions: _____ Special Needs: _____

Chronic /recurring Illness: _____ Special Diets required: _____

Other information that may be helpful to the Centre and doctor in case of a Medical need:

_____

_____

***IMMUNIZATIONS***

Immunization records must be given in at the Centre on or before the child's first day of care.
**PLEASE NOTE: No Child will be accepted in the centre that has not been immunized.**

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## ***Emergency Release***

### Consent to Emergency First Aid & Transportation:

I _____hereby give permission that my child _____, may be given first aid treatment by a staff member at Child Plus Learning Centre. I also give permission for my child to be transported by car, ambulance or aid car to an emergency centre for treatment, and agree not to hold Child Plus Learning Centre and it's employees liable.

Parent's Signature: _____ Date:_____

### Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician and agree to hold Child Plus Learning Centre and it's employees harmless.

Parent's Signature: _____ Date:_____

## ***PARENTS CONTRACT AGREEMENT***

I _____ have read this contract and will comply with all provisions contained herein. I have also agreed to enter into an agreement with Child Plus Learning Centre for the care of my /our child/children _____

With the understanding that we shall work together on behalf of the child.

This agreement will remain in effect until a change is mutually agreed upon in writing or upon termination of our child care service. The agreement is further subject to review and renewal on a yearly basis.

Signed: _____Date: _____
(Parent or Guardian)
Signed: _____ Date: _____
(Child Plus Learning Centre)

Date Child is schedule to arrive at the Centre:_____

Date Child is schedule to leave at the Centre:_____

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| **ACCIDENTAL DEATH & DISMEMBERMENT** | **Amount Paid** |
|---|---|
| • Face Amount | $400,000.00 |
| • Death by Accident Coverage | 100% |
| • Loss of two limbs or sight of both eyes or speech or hearing | 100% |
| • Loss of any one limb or sight of one eye | 50% |
| • Loss of one digit | 25% |
| • Loss of one thumb or index finger | 25% |

| **MEDICAL EXPENSES** | **Amount Paid** |
|---|---|
| As a result of an accident:- | |
| • Ambulance services to hospital | $1000 |
| • Doctors Visit, Dressing, Suturing, Emergency Hospital Bed And other emergency related cost | 90% |
| • Maximum per accident | $120,000.00 |
| • Dental Limits | $10,000.00 |
| • Optical Limited- replacement of broken legs as a result of Accident at the center which required medical attention | $ 1,500.00 |
| • Co-payment claim | 10% |

## HEALTH COVERAGE CONSENT FORM

Detach along broken line, complete this section and submit it to the office along with payment.

**Annual premium $ 500.00**

CHILD'S NAME: _____

DATE OF BIRTH_____

NAME OF PARENT/ GUARDIAN_____

PARENT/GUARDIAN SIGNATURE_____