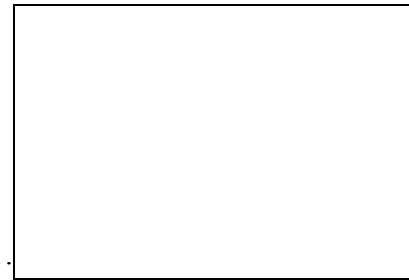


**EARLY CHILDHOOD DEVELOPMENT CENTRE
STUDENT ADMISSION RECORD
REGION 6**



REFERENCE NO DATE.....

NAME OF ECDC.....

NAME OF CHILD SEX.....

DATE OF BIRTH..... BIRTH CERTIFICATE NO.....

RELIGIOUS AFFILIATION.....

LAST ECDC ATTENDED.....

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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 email: childplus@gmail.com

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 APPROPRIATE 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					

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?

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.

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: _____

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 _____

APPENDIX II

Early Childhood Institution-Child's Medical Report

Part A **TO BE COMPLETED AND SIGNED BY PARENT/ GUARDIAN**

NAME OF EARLY CHILDHOOD INSTITUTION _____

CHILD'S NAME _____

DATE OF BIRTH _____ AGE ____ YRS ____ MTHS SEX: M F

ADDRESS _____

_____ TELEPHONE NO _____

NAME OF PARENT/ GUARDIAN _____

ADDRESS (H)

ADDRESS (W)

TELEPHONE NO (W) _____ (H) _____ (CELL) _____

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

NAME _____ RELATION _____ TEL. NO _____

ADDRESS _____

FAMILY DOCTOR/HEALTH CLINIC _____

ADDRESS _____

TELEPHONE NO _____

MEDICAL HISTORY

Please respond by putting a tick (✓) under the appropriate column and record dates of last treatment and remarks for positive responses

Has your child ever been diagnosed or treated for any of the following condition?

<u>Past history</u>	YES	NO	DATE	REMARKS
❖ Asthma	()	()	_____	
❖ Bronchitis	()	()	_____	
❖ Tuberculosis (TB)	()	()	_____	
❖ Disorders of the Ears/ Nose Throat	()	()	_____	
❖ Rheumatic fever/ Rh Heart Disease	()	()	_____	
❖ Heart Disease	()	()	_____	
❖ Epilepsy (Fits)	()	()	_____	
❖ Mental Disorders	()	()	_____	
❖ Learning Disability	()	()	_____	
❖ Physical Disability	()	()	_____	
❖ Disorders of the Kidney/bladder	()	()	_____	
❖ Disorders of Stomach/Bowels	()	()	_____	
❖ High Blood Pressure	()	()	_____	
❖ Diabetes Mellitus (sugar)	()	()	_____	
❖ Leukemia/ Lymphoma	()	()	_____	
❖ Typhoid	()	()	_____	
❖ Headaches	()	()	_____	
❖ Anemia (weak blood)	()	()	_____	
❖ Fainting spell/ giddiness	()	()	_____	
❖ Excess Tiredness	()	()	_____	
❖ Visual disorder	()	()	_____	
❖ Hearing disorder	()	()	_____	
❖ Hepatitis B	()	()	_____	
❖ Meningitis	()	()	_____	
❖ Allergies to medication	()	()	_____	

List _____

❖ Other condition _____ () () _____



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HAS YOUR CHILD EVER BEEN ADMINTED TO HOSIPTAL OR HAD SURGERY? YES NO

If yes , please explain for what reason

REGULAR MEDICATION TAKEN (IF ANY) _____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Asthma	()	()	_____
❖ Allergies	()	()	_____
❖ Diabetes Mellitus	()	()	_____
❖ Tuberculosis	()	()	_____
❖ Cancer/ Tumors	()	()	_____
❖ Sickle Cell Disease	()	()	_____
❖ Mental Disorder	()	()	_____
❖ Migraine	()	()	_____
❖ High Blood Pressure	()	()	_____

I certify that the above information is correct

SIGNATURE _____
(PARENT/ GURADIAN)

DATE _____



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PART B MEDICAL EXAMINATION REPORT – To be completed by a physician

Please give details of findings and verify immunization history

CHILD'S

NAME _____ 02 _____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

BP _____ URINALYSIS PROTEIN _____ SUGAR _____

GENERAL APPEARANCE _____ NUTRITIONAL STATE _____

POSTURE _____ TEETH/GUMS _____

SKIN _____ HAIR/SCALP _____

EYES _____ VISION R _____ L _____

(INDICATE WHETHER TESTED WITH GLASSES OR NOT)

EARS _____ NOSE _____ THROAT _____ HEARING _____

BREAST _____ THYROID _____

RESPIRATORY SYSTEM _____

CARDIVASCULAR SYSTEM _____

ABDOMEN/ GI SYSTEM _____

CENTRAL NERVOUS SYSTEM _____

BONES AND JOINT _____ DEFORMITIES/ DISABILITIES _____

GENITO URINARY SYSTEM _____



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Immunization History: Please indicate date

DOCTOR'S NAME (WRITTEN)

MOJ REG#

DATE