All About Your Child

Child's Full Name_____Nickname_____

I have _____ brother(s) and _____ sister(s). Their name and ages are_____

_____.

Has your child been in a preschool before? Yes _____ No _____

If yes, name of preschool_____

Has your child been in a daycare before? Yes _____ No _____

If yes, name of provider or center _____

Dates care was provided _____

Does your child have a special diet? _____

Are there any foods that should not be served to your child/food allergies?

_____

How many hours of sleep does your child typically get each night? _____

Does your child take naps? _____ If so, how long does your child nap? _____

Health Concerns:

Does your child have any known health concerns? Yes _____ No _____

If yes, please describe

_____

_____

Does your child take any medications on a regular basis? Yes _____ No _____

If yes, please list the medication(s), dosage, and how often taken_____

Are there any hearing or vision problems? If yes, please describe

_____

_____

Does your child have any known allergies? Yes _____ No _____

If yes, please list the allergy and how it is dealt with_____

_____

Is your child able to effectively communicate his/her needs and wants? Yes_____ No___ If no, please describe_____

_____

Does your child suffer from any of the following on a regular basis (check all that apply)?

Nosebleeds_____ Headaches_____ Sore throats_____ Stomachaches_____

Runny nose_____ Seasonal allergies_____ Other _____

Anything else we should know about your child?

_____

My child is _____Left _____Right handed.

Tuition Contract

I understand that the $75 enrollment fee and activity fee are due and payable at the time of enrollment and that September's tuition is due September 5, 2017. I understand that I am contracting for the full year, September through May, at the tuition rate of _____and agree to pay _____ each month, in accordance with the fees charged for the class(es) in which my child is enrolled.

I further understand that in the event my child ceases to be enrolled for any reason whatsoever in the preschool program, I am not entitled to a refund of the enrollment fee once the school year has started. If I choose not to attend Go Beyond Preschool prior to the beginning of the school year, I will be refunded $40 of the enrollment fee.

I understand and agree that when my child exhibits the health symptoms outlined in the Parent Handbook, she/he may not attend the program for the time period specified in accordance with the North Dakota Department of Health.

I hereby grant permission for my child to use all of the play equipment and to participate in all of the school activities. I grant permission for my child to leave the school under the supervision of the teacher or director for walks. I grant permission for my child to be included in evaluations and pictures connected with the school program.

I understand that all information in the Parent Handbook concerning the program for which my child is enrolled will apply.

My child will attend:

Tuesday/Thursday AM session_____

Monday/Wednesday/Friday AM session_____

Monday-Thursday PM session_____

_____ _____

Parent Signature Date

Photo/Video Release Form

I, _____ (parent/guardian) give permission to Go Beyond Preschool to take pictures/video of _____(child). These pictures/videos may be used for advertising purposes (brochures, magazines ads, etc.) or on the Go Beyond Preschool website. I understand that names of the children will not be used or shared.

_____
Print Name of Child

_____ _____
Signature of Parent/Guardian Date

Emergency Medical Care/Authorization Form

In order to meet all legal requirements, I hereby authorized any representative of Go Beyond Preschool to give consent for any and all necessary emergency medical care for my child (name) _____ while said child is in said individual's custody.

_____ _____

Date Parent Signature

Physician_____ Phone number _____

Hospital Preference _____

Do you have health insurance? Yes_____ No_____

Policy Name and # _____

Do you receive medical assistance? Yes_____ No_____

Program and Card # _____

CHILD INFORMATION SHEET

ND DEPARTMENT OF HUMAN SERVICES
CHILDREN AN D FAMILY SERVICES
SFN 845 (12-2013)

Every Early Childhood Program is required to have certain information on file. These requirements are set forth in the rules and regulations for Early Childhood Services as adopted by the North Dakota Department of Human Services. All information requested herein is required and shall be kept confidential.

Child's Name	Date Child Enrolled	Preferred or Nickname of Child	Date of Birth
Mother's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work
Father's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work

EMERGENCY AUTHORIZATION

In case of an emergency and parents cannot be reached, who should be contacted?

Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Physician to Call in an Emergency			Clinic Telephone Number
Dentist to Call in an Emergency			Clinic Telephone Number

I hereby authorize the Early Childhood Program to secure emergency medical treatment for my child under the following conditions:

1. An emergency or unanticipated condition necessitates immediate action for the preservation of the life or health of the child, and
2. Reasonable attempts to contact me have failed.

Parent Signature	Date	Parent Signature	Date

AUTHORIZATION TO RELEASE CHILD

Unless otherwise authorized by you in writing, only the parent or legal guardian may pick up your child(ren) from the Early Childhood Program. List below any others you wish to authorize for this purpose.

Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number

These people are NOT allowed to pick up my child.

Name	Relationship to Child
Name	Relationship to Child

For Operator Use Only:

The identification of this child has been verified. As proof of identification, the child's parent has produced: ☐ Copy of Child's Birth Certificate ☐ Child's Passport ☐ Other _____
Signature of Operator

Download a fillable SFN845 form at http://www.nd.gov/eforms/Doc/sfn00845.pdf

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

Download a fillable SFN847 form at http://www.nd.gov/eforms/Doc/sfn00847.pdf

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 05-2012)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

North Dakota law requires this form be completed* and provided to the childcare facility or school.

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Check type below€	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B	☐					
Rotavirus	Rotavirus	☐					
Hib	*Haemophilus influenzae* type B	☐					
PCV	Pneumococcal conjugate	☐					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis	☐					
OPV/IPV	Polio	☐					
MMR	Measles-Mumps-Rubella	☐					
Varicella	Chickenpox	☐			**History of Disease Date:**		
Hepatitis A	Hepatitis A	☐					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	☐					
MCV4	Meningococcal	☐					
HPV	Human Papillomavirus	☐					
Other		☐					

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health	Title	Date

If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.

Parent/Guardian Signature: Date:

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical Exemption: **The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.**

Physician Signature:	Date:

€***Exemption:*** *(Indicate vaccine above)*

(Please check one) ☐ Religious ☐ Philosophical ☐ Moral ☐ History of Disease

Parent/Guardian Signature	Date