



- Enrollment Form (3 pages) – updated annually
- Photo Release form
- Immunizations- must be received within one week of start date
- Health Statement
 - Physician’s Statement OR
 - Parent Statement (including name and address of health-care professional who has examined the child within the past year stating that the child is able to participate in the program.) Followed by signed Physician’s Statement within ONE YEAR of admission date
- Parent Handbook Acknowledgement
- Toilet Training Guidelines (if applicable)
- Financial Contract

Physical address: 1215 S. Wall St. Belton, TX, 76513
Mailing address: 2109 W. Ave. H, Temple, TX 76504

office: 254-773-3898

bbmdo.iltexas.org

Bright Beginnings Mother's Day Out at Immanuel-Prince of Peace Lutheran Church—Enrollment Form Page 1

Child's Full Name _____ Date of Birth _____

Preferred Name _____ Gender Male Female

Child lives with _____ Parent's Marital Status _____ # of Siblings _____

Date of Enrollment Application _____ Requested Beginning Date _____
(new enrollment only)

Name of Mother/Guardian _____

Relationship to child _____ Home phone # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Check the phone # you want the staff to call **first** in case of emergency or concern.

Work # _____ Ext. _____ Work Hours _____

Cell # _____ Other # _____

Email address: _____ Driver's License # _____

Name of Father/Guardian _____

Relationship to child _____ Home phone # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Check the phone # you want the staff to call **first** in case of emergency or concern.

Work # _____ Ext. _____ Work Hours _____

Cell # _____ Other # _____

If divorced, who has legal custody? _____

May the non-custodial parent pick up the child? Yes No*

If no, documentation from the court is required.

I understand that Bright Beginnings Mother's Day Out and Immanuel-Prince of Peace does not provide accident insurance coverage.

Parent/Guardian Signature

Date

Bright Beginnings Mother's Day Out at Immanuel-Prince of Peace Lutheran Church—Enrollment Form Pg 2

Emergency Contact (List a person who will assume responsibility if parent cannot be reached.)

Name: _____ Relationship to child _____
Address _____ City _____ State _____ Zip _____
Phone numbers to be reached during hours of operation
(1) _____ (2) _____
Driver's License # _____

Emergency Contact (List a person who will assume responsibility if parent cannot be reached.)

Name: _____ Relationship to child _____
Address _____ City _____ State _____ Zip _____
Phone numbers to be reached during hours of operation
(1) _____ (2) _____
Driver's License # _____

Emergency Medical Care *In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the staff of Bright Beginnings and Immanuel-Prince of Peace to seek assistance from the following physician and/or have my child transported for emergency care to the following emergency medical care facility.*

Physician's name _____ Clinic _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Emergency Care Facility Name _____ Phone # _____
Address _____ City _____ State _____ Zip _____

I give consent for the staff of Bright Beginnings and Immanuel-Prince of Peace to secure any and all necessary emergency medical care for my child.

Parent/Guardian Signature

Date

Authorized Pick-up Release (additional names may be listed on back of form)

Name: _____ Relationship to child _____
Phone # during hours of operation _____ Driver's License # _____

Name: _____ Relationship to child _____
Phone # during hours of operation _____ Driver's License # _____

Name: _____ Relationship to child _____
Phone # during hours of operation _____ Driver's License # _____

I authorize that my child can be released from the care of Bright Beginnings to the individuals indicated above in addition to those already listed on this form.

Parent/Guardian Signature

Date

Bright Beginnings Mother's Day Out at Immanuel-Prince of Peace Lutheran Church—Enrollment Form Pg 3

Child's Name _____ Date of Birth _____

Child's Health Information

Does your child have any known allergies? Yes No

If yes, what kind? _____

How do these allergies affect your child? Check all that apply.

Minor irritation Severe reaction Hives affects airway/swelling/swallowing

How are these allergies typically treated? _____

Does your child take daily medications? Yes No

If yes, what kind and how often?

Is there any other information we should know to help us better care for your child? _____

To the best of my knowledge, I have completed the health information about my child

Parent/Guardian Signature

Date

Information for the Teachers

1. Has your child had any other group experiences (Check all that apply)

Sunday School Daycare Play dates Church Home Care

Other _____

2. Does your child have separation anxiety? Yes No

3. Does your child have any fears? Yes No If so, please explain _____

4. Are there any pets at home? Yes No If so, what kind _____

5. Have you had a significant event in your family in the last six months? Yes No

Please check all that apply: Move Divorce Separation Deployment Birth

Death Other: _____

Potty Training

Is your child potty trained? Yes No

Will your child let the teacher know when he/she has to go potty? Yes No

At what age do you plan on starting the potty training at home? _____

Bright Beginnings Mother's Day Out
Immanuel Lutheran Ministries
Photo release

I, _____, hereby authorize Immanuel Lutheran Ministries and Bright Beginnings MDO (ILM) to publish the photographs taken of _____ a minor child, WITHOUT their name for use in ILM printed publications, media, and website.

I release ILM from any expectation of confidentiality for the above-named minor child and attest that I am the parent or legal guardian of the child listed above and that I have the authority to authorize ILM to use the above-named minor child's photographs and name.

I acknowledge that since participation in publications and websites produced by ILM is voluntary, neither the minor nor I will receive any financial compensation.

I further agree that participation in any publication and website produced by Immanuel Lutheran Ministries confers no rights of ownership whatsoever. I release Immanuel Lutheran Ministries, its contractors and its employees from liability for any claims by me or any third party in connection with participation of the undersigned minor child.

Parent/Guardian Signature: _____ Date: _____

Full Name of Minor Child: _____ Age: _____

Bright Beginnings Mother's Day Out
Parent Acknowledgement

Name of Student: _____

Date of Enrollment: _____

I have read and understand the policies of Bright Beginnings Mother's Day Out as outlined in the Parent Handbook and Policy handouts. I agree to abide by these policies and acknowledge that failure to do so may result in my child's dismissal from the Center.

Parent Signature

Legal Guardian if other than above

Date

Bright Beginnings Mother's Day Out
Immunizations and Physician's Statement

Child's Name _____ Date of Birth _____

Vaccine	Birth	1 month	2 month	4 month	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hepatitis B											
Rotavirus											
DTaP											
Hib											
IPV/OPV											
Influenza											
MMR											
Varicella											
Hepatitis A											
Meningococcal											

Signature or stamp of a physician or public health personnel verifying immunization information above.

Signature

Date

___ I am excluding my child from the immunization requirements for reasons of conscience, including religious belief. I have attached an official notarized affidavit form developed by the Department of State Health Services. I understand the affidavit is valid for two (2) years.

Physician's Statement

Child's Name _____ Date of Birth _____

I have examined the above-named child within the past year and find that he/she is physically able to participate in activities at Bright Beginnings Mother's Day Out and Immanuel Lutheran Ministries.

Physician's Signature _____
Date

Physician's Address: _____

Phone _____ Fax _____

List any medications taken regularly by this child. _____

Any known allergies? _____

Any other special physical conditions?

Parent/Guardian Signature

Date