

LIVING WORD CHURCH OF THE NAZARENE

MOTHER'S DAY OUT

ENROLLMENT FORM

Child's Name _____ Birth month ___ day ___ year _____
 Sex _____ Place of Birth _____ Nationality _____
 Current Address _____ City _____ Zip _____
 Person Child Lives With _____ Relationship _____
 Phone Number _____ Emergency Phone Number _____

FAMILY

Name of Mother or Guardian _____ Age ___ Cell _____
 Work Phone _____ Occupation _____
 Name of Father or Guardian _____ Age ___
 Occupation _____ Work Phone _____ Cell _____
 Marital Status of Parents _____ If child is adopted, list age at adoption _____
 Is child aware of adoption? ___ List siblings and ages _____

 Are there other members of the household? ___ If so, list name, age, and relationship, _____

HEALTH AND OTHER RELATED ISSUES

Is your child toilet trained? ___ Is assistance needed? ___ How does your child indicate the need to go to the restroom? _____
 Does your child nap? ___ Usual nap time? _____ What time does your child go to bed at night? _____
 Wake up time? ___ Does your child have any special fears? _____
 Does your child have any problems with vision or hearing? ___ If so, does your child require any assistance in any manner? ___ Please explain _____
 Does your child have any health problems that we should be aware of? _____

 Are there any food or drinks that your child is allergic to or should NOT have? _____

Please underline any terms below that describes your child:

Happy	Aggressive	Friendly	Moody	Clumsy	Dependent	Stubborn
Impulsive	Fearful	Creative	Attentive	Shy	Sympathetic	Sleepy
Quiet	Independent	Good-natured	Even-tempered			

Has your child learned to... Say nursery rhymes? ___ Sing songs? ___ Listen to stories? ___ Say his/her name? ___
 State his/her age and sex? ___ Dress self independently? ___ Recognize and name common objects? ___
 Count? ___ How far? ___ Follow simple directions? ___ Hop on one foot? ___ Name basic colors? ___
 Balance on one foot? ___ Throw and catch a ball? ___ Ride a tricycle? ___
 Other? (Please list any significant accomplishments) _____

Has your child been to another country? ___ When? _____ Where? _____
 Has your child had play group experience? ___ When? _____ Where? _____
 Has your child been cared for by anyone besides the family? ___ Please describe _____

CHURCH BACKGROUND

Church affiliation of family _____ Does child attend? ___ How often? _____
Do parents attend? ___ Has child attended a church nursery? ___ Has child participated in Bible classes? ___
Mother's Day Out does provide a Bible class daily. Will there be a problem having your child participate in this class? ___

EMERGENCY INFORMATION

Persons authorized to pick up your child:

Name _____	Phone number _____	Relationship _____
Name _____	Phone number _____	Relationship _____
Name _____	Phone number _____	Relationship _____

Persons to be notified in case of an emergency:

Name _____	Phone number _____	Relationship _____
Name _____	Phone number _____	Relationship _____
Name _____	Phone number _____	Relationship _____

Do you have any concerns about any aspect of your child's development? _____

List any serious illnesses your child has had _____

Does your child have frequent... Colds? ___ Earaches? ___ Sore throats? ___ Fever? ___ Stomach aches? ___
Nose bleeds? ___

Has your child had any serious accidents or operations? _____

Are there any serious medical, physical, or emotional needs that the staff should be aware of? _____

When was your child's last doctor's visit? _____ Why? _____

Dentist? ___ Why? _____

Has your child been immunized? ___ Is the immunization record up to date? ___ A copy must be submitted for enrollment.

Age at which your child... Crawled on hands and knees _____ Sat alone _____ Walked _____
Sat in high chair _____ Sept through the night _____ Was potty trained _____

Do you feel that your child's speech is clear? ___ Can strangers understand when your child speaks? ___

Is your child fluent in English? ___ Is any language other than English spoken in the home? ___
If so, does your child speak this language? ___ What is the language? _____

HOME LIFE

How much television does your child generally watch each day? _____

What activities does your child enjoy? _____

What does your child enjoy doing with mother? _____

What does your child enjoy doing with father? _____

Does your child play well alone? ___ In groups? ___ Are there neighborhood playmates? ___

What are the ages of the children that your child usually plays with? _____

Does your child accept correction easily? ___ What is the method of behavior control used in your home? _____

Child's Physician _____ Phone _____

Address (street/city/zip) _____

Emergency Hospital Preference _____

By signing below, I agree to pay all fees and late fees that may be added to my account. I also agree that Living Word Church of the Nazarene will not be financially responsible for any injuries or illnesses that may occur while my child attends the Mother's Day Out program.

_____ Date _____

Parent's signature

PHOTO/VIDEO PERMISSION

From time to time, our classroom teachers enjoy taking photographs of the children to post in the classroom and hallway. There are also times that we would like to video a class and show the video to the children and other parents. Any photos or videos that are taken would be used in-house only.

Mother's Day Out has permission to take photographs' of my child _____
(child's name)

Signed _____
(parent's signature)

Date _____

OFFICE USE ONLY

Date form received _____ Date enrollment fee received _____ Amount _____ Cash/Check# _____

MOTHER'S DAY OUT MEDICAL RELEASE FORM

I authorize Mother's Day Out to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care in case I am not immediately available. Any qualified physician called by Mother's Day Out may treat and do whatever is necessary for the health and well being of my child. I ask that a conscientious effort be made to notify me before such action is taken. I agree to accept responsibility for the cost of any medical services.

Name of child _____ D.O.B. _____
 Home address _____ City/Zip _____
 Home telephone _____
 Insurance carrier _____ Policy # or Group # _____
 Physician's name _____ Phone _____
 Address _____ City/Zip _____
 Mother _____ Cell _____
 Employed by _____ Business phone _____
 Father _____ Cell _____
 Employed by _____ Business phone _____
 Neighbor or nearest relative _____
 Address _____ City/Zip _____
 Phone _____

Parent signature _____

Parent signature _____

This form must have two signatures unless your child is in the custody of one parent.

Acknowledgment Certificate

State of _____ County of _____

On this _____ day of _____, 20____,

____ personally appeared before me,
 ____ who is personally known to me
 ____ whose identity I prove on the basis of _____
 ____ whose identity I prove on the oath/affirmation of _____

A credible witness to be the signer of the above instrument, and he/she signed it.

Notary Public Signature _____

Notary's Printed Name _____

My commission expires _____

MOTHER'S DAY OUT PHYSICIAN'S FORM

Child's Name _____ Birth month ___ day ___ year _____

Parent's name _____ -

HEALTH EXAMINATION: a complete examination was given on month ___ day ___ year _____

IMMUNIZATIONS

DATES

Pertussis/Diphtheria/Tetanus 1. _____ 2. _____ 3. _____ 4. _____
(2-3 mos) (4-5 mos) (6-11 mos) (15 mos-4yrs)

Polio 1. _____ 2. _____ 3. _____
(2-3 mos) (4-11 mos) (12-14 mos)

Mumps/Measles/Rubella 1. _____ 2. _____
(After 1st birthday) (before entering Kindergarten)

HIB 1. _____ 2. _____ 3. _____ 4. _____
(2-3 mos) (4-5 mos)

HEP B 1. _____ 2. _____ 3. _____

Chicken Pox _____ or History _____

TESTS

Tuberculin Skin _____ Results _____

Chest X-Ray _____ Results _____

Four Year Olds Only: Vision test results _____
Hearing test results _____

HISTORY OR DISEASES

Polio _____ Diphtheria _____

Scarlet Fever _____ German Measles _____

Tuberculosis _____ Measles _____

Physical defects or other impairments _____

Existing illnesses _____

MOTHER'S DAY OUT INFANT CARE INSTRUCTION FORM

Infant's Name _____ Birth month ___ day ___ year _____

Type of Formula (Be specific) _____ Warm? ___yes ___no

ALLERGIES

Food _____

Skin _____

Other _____

Symptoms produced _____

Skin care ointment _____

Special soap _____

Sleeping positions: ___On stomach ___On back ___On side

Does your baby use a pacifier? ___Yes ___No

Other helpful information (Please include schedule for feeding, sleeping, etc.)

(parent's signature)

(Date)

Note: Please update this information as changes are made.