Updated _____
Teacher _____

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Board of County Commissioners, Broward County, Florida BROWARD COUNTY SOCIAL SERVICES DIVISION CHILD CARE PROGRAM CHILD ENROLLMENT INFORMATION

Preferred Name:_____ Four (4) Digit Entry Code: _____

Child's Name _____ Date of Enrollment_____/_____/_____

Address_____ City/Zip _____

Sex : M or F D.O.B. ____/_____/____ School Grade: K, 1, 2, 3, 4, 5

NAME	HOME ADDRESS	PHONE
Mother_____	_____	**( )**_____-_____
Father_____	_____	**( )**_____-_____
Guardian_____	_____	**( )**_____-_____

Mother Cell Phone(____)_____ Father Cell Phone (_____)_____

Email Address _____ Email Address _____

Mother_____ _____( )_____ _____
Place of employment Occupation phone/extension

Father_____ _____ ( )_____ _____
Place of Employment Occupation Phone/extension

Parents Marital Status: S M D or W

Child's Physician_____

Address of Physician_____ Phone _____

May the center call another physician if unable to contact the above? _____

Persons permitted to remove child: <u>Mother:</u> Yes or No <u>Father</u>: Yes or No

In case of an emergency or illness, other persons to be notified and permitted to remove child from center:
(Must be 18 years of age to remove child from center)

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Signature of person enrolling child : _____

EMERGENCY INFORMATION

Name of Child: _____D.O.B_____

Name of Child's Doctor:_____Phone:_____

Person authorized to act for parents in emergency:

First Choice:
Name:_____ Home Phone: _____ Work:_____
Address:_____

Second Choice:
Name:_____ Home Phone:_____ Work:_____
Address:_____

Medical History:

Measles: Yes or No Mumps: Yes or No Chicken Pox: Yes or No
Convulsions:_____
Allergies (food, medicine, etc.):_____
_____

Any evidence of hearing difficulty? Yes or No Explain:_____

Any evidence of visual difficulty? Yes or No Explain:_____

Birthmark: Yes or No Explain: _____

Speech disabilities? Yes or No Explain:_____

Hospitalizations? Yes or No Explain:_____

Operations? Yes or No Explain: _____

Other illnesses?_____

Does your child have any physical handicaps or conditions which might affect his/her schooling?_____ Please describe: _____
_____
_____

Briefly describe your child as a person: likes, dislikes, favorite past times, toys, friends, toilet habits, napping needs, etc. In essence, please include anything that will help us to
understand your child and help him/her grow:
_____
_____
_____

Board of Broward County Commissioners, Broward County Florida
SOCIAL SERVICES DIVISION
CHILD CARE PROGRAM

ALTERNATE NUTRITION PLAN

Date_____

Name of Facility: City of Pembroke Pines
Early Learning Center – West Campus
Address: 1600 SW 184th Ave
Pembroke Pines, Fl 33029

Dear Parent,

In accordance with the Broward County Child Care Ordinance, parents and the child care facility are urged to work cooperatively to assure that children are provided with nutritious snacks and meals where lunches are not provided by the facility.

Please read the following carefully, sign and return as soon as possible to the Site Supervisor.

The facility agrees to provide a nutritious:
(Director checks those which apply)

_____breakfast
_____x_____mid-morning snack
_____x_____mid-afternoon snack
_____no meals or snacks

The parent agrees to provide a nutritious:

_____mid-morning snack
_____x_____lunch
_____mid-afternoon snack

I have read the preceding and agree to meet the child's nutritional needs as defined above.

_____
Caretaker/School Director Signature

_____
Parent/Guardian Signature

Parent - please tear and keep this portion

Meals provided by parents ought to consist of the following:

A.	Meat/Poultry/Fish	2 ounces
	or cheese	2 ounces
	or eggs	1 egg
	or peanut butter	4 tablespoons
	or dried beans and peas	1/2 cup
B.	Fruits (2 or more)	1/2 cup
	or vegetables	1/2 cup
	or fruits and vegetables	3/4 cup total amount and vegetables must equal 3/4 cup
C.	Bread	1 slice
D.	Butter	1 teaspoon
E.	Milk	1 cup - 8 oz.

PARENT'S STATEMENT

In making application for my child to attend The City of Pembroke Pines Pre-School West Campus, I agree to support the moral, educational and disciplinary standards of the school.

It is important for home and school to work together in establishing appropriate behavior

.

I give permission for my child to take part in all school activities, I will always be told of any field trips in advance and will sign a permission slip or my child will not be permitted to leave the school's premises

.

I agree to pay the tuition and any charges.

I agree that I will NOT send my child to school sick.

I also understand that this application cannot be considered without the registration fee.

In the event my child becomes ill or injured while under school supervision:

1. If the illness or injury is minor, the parent/guardian will be contacted.
2. If the illness or injury is more serious and/or life threatening 911 will be called
3. Parent hereby release the City of Pembroke Pines Early Development West Campus Preschool from any liability which might arise from giving such authorization, it being the parent desire to have child furnished medical or surgical services as soon as reasonably possible after illness or injury arises.

Child's Name: _____

Print Parent's or Guardians Name: _____

Parent's /Guardian Signature:_____

Date:_____

MEDIA RELEASE

From time to time during the school year, the media and the graphics department photographs our school, staff, and students to visually explain the many and varied types of programs and events which we offer. Those photographs or video tapes may be used in newspapers, on television, on our preschool web site, or in other appropriate publications.

Your signature below indicates your permission for your child to be photographed for such purposes. Please sign and return this form as soon as possible.

Child's Name: _____

Print Parent's/Guardian's Name:_____

Signature of parent/guardian: _____Date: _____

MEDICAL RELEASE

Dear Parent,

In order to comply with the Broward County Child Care Code, please provide us the following information. Our preschool shall have written instructions from parents for the school to follow in arranging for immediate treatment for your child in an emergency situation.

Below, you will find the necessary form that will need to be filled out for our records. Please detach and hand in. If you have any questions concerning this matter, please feel free to contact us. Thank you in advance for your cooperation.

Sincerely,
Delsa M-Vazquez
Delsa Vazquez
Site Supervisor

1. By my signature below, I give the City of Pembroke Pines Early Development Central West Campus Preschool authorization to seek medical treatment for my child if I or any other persons for whom I have listed to be notified in case of emergency cannot be reached.
2. By my signature below, I give any health facility or physician permission to provide medical treatment for my child as necessary in any emergency situation which may arise at the Preschool.
3. By my signature below, I will take full responsibility for payment of all medical services which might be rendered due to any emergency situation that may arise at the Preschool.

Child's Name: _____

Print Parent's/Guardian's Name:_____

Signature of parent/guardian: _____

Date: _____

DISCIPLINE POLICY

The Center will ensure that age appropriate, constructive disciplinary practices shall be used for children in care.

Children shall not be subjected to discipline which is severe, humiliating or frightening.

Discipline shall not be associated with food, rest or toileting. The child might be brought to the office if the teacher feels the child might be a danger to himself or others.

Please sign below, detach and return bottom portion to the center supervisor as soon as possible.

I _____, have read the Preschool's Discipline Policy.

Child's Name: _____

Print Parent's/Guardian's Name: _____Date: _____

CITY OF PEMBROKE PINES

EARLY CHILDHOOD LEARNING PROGRAM

RELEASE AND WAIVER OF LIABILITY

Child's Name: _____

It is hereby acknowledged that every possible precaution will be taken to safeguard my child while attending the City of Pembroke Pines Early Development Center West Campus Preschool. For and in consideration of my child's participation and registration at the City of Pembroke Pines Early Development Center West Campus Preschool, and on behalf of myself and my child, our respective heirs, administrators, executors and successors, I/we hereby covenant not to sue and forever release and hold harmless the City of Pembroke Pines, its officers, directors, agents and employees from any and all liability (including attorneys' fees and costs) for any cause of action for personal injury, property damage or wrongful death occurring while my child is under the instruction, supervision or control of the City of Pembroke Pines including, without limitation, those damages or injuries resulting from acts of negligence on the part of the City, its officers, directors, shareholders, employees or agents while my child is in attendance and on the premises at the Early Development Center West Campus.

_____

Print name of Parent/Guardian

_____

Signature of Parent/Guardian Date

○ Bright Beginnings ○ Central EDC ○ East EDC ○ West EDC

Child's Name: _____

All fees are to be paid in advance. TUITION IS NOT SUBJECT TO ADJUSTMENT DUE TO ABSENCE FROM THE CENTER, WITHDRAWAL, HOLIDAYS OR OTHER CIRCUMSTANCES.

We accept cash, Money Orders and Checks only. Please make all checks to: City of Pembroke Pines
Any check issued to the city that is returned by the bank for insufficient funds, account closed, stop payment, refer to maker, no account found or other will be assessed a returned check fee as in166.251, Florida Statues, as amended from time to time. 166.251, Florida Statues, provides for the following fees:

Twenty-five dollars, if the face value does not exceed $50
Thirty dollars, if the face value is more than $50 but does not exceed $300
Forty dollars, if the face value is more than $300 but does not exceed $800
5% of the face value if the face value exceed $800

In the event a dishonored check is not paid in accordance with Chapter 166.251, Florida Statues, appropriate legal action may be filed for the full amount of the returned checks due and owing together with services charges, court costs, and reasonable attorney's fees as provided by law.

When a costumer issues three (3) returned checks on any City account during the most recent twelve (12) months, his/her check payment privileges at the City of Pembroke Pines will be suspended for a period of six (6) months.

Subsequent returned checks received after the reinstatement of check writing privileges, will result in an additional six (6) months suspensions.

Payment to satisfy a returned check will only be accepted by cash, money order, or cashier's check.
Past due accounts without satisfactory arrangements with the Site Supervisor shall result in your child not being able to attend the center until your account is brought current.
Fees and policies for The City of Pembroke Pines programs are subject to change

Parent or guardian: By signing this agreement, I (we) agree to pay all amounts when due under this agreement. I have read and received a copy of this agreement and agree to all of its terms.

Payment Agreement

MOTHER OR GUARDIAN
Name: _____
Driver's LIC #: _____
Signature: _____Date_____

FATHER OR GUARDIAN
Name: _____
Driver's LIC #: _____
Signature: _____Date_____