STEPPING STONES
PREPARATORY ACADEMY

Child's name (last, first, middle): Name called: Age: Sex: Birthdate:

Father's name (last, first, middle): DL# Please circle one: Dr. Mr.

Address (street, city, state, zip): Home phone: (please indicate which # to call first)

Place of Employment: Work phone/cell phone: Email Address:

Mother's name (last, first, middle): DL# Please circle one: Dr. Mrs. Ms.

Address (street, city, state, zip): Home phone: (please indicate which # to call first)

Place of Employment: Work phone/cell phone:

Person(s) authorized to pick-up child other than parent (name, address, phone, driver's license#):

Person(s) to contact in emergency (should both parents be unavailable):

Program in which child will be enrolled:
Infants Pre-Toddlers Toddlers Pre-school Private School After-school

Time: from____ to____ Numbers of days each week: M T W Th F

Beginning Date:

Private Physician: Address: Phone:

Hospital:

Public/Private School Attending: Address: Phone:

His/ Her immunization record is on file at the school and all required immunizations and /or Tuberculosis test are current. Vision and Hearing records are also on file.

Authorizations:

I hereby authorize Stepping Stones to share all health information regarding my child with all relevant Stepping Stones employees, and I authorize Stepping Stones to share my contact information for classroom directories.

Parent/Guardian Signature Date

I hereby authorize Stepping Stones personnel to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached.

Parent/Guardian Signature Date

I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named physician cannot respond.

Parent/Guardian Signature Date

I hereby authorize Stepping Stones personnel to transport my child to or from school, on educational excursions, or on other center sponsored activities under proper supervision and adequate transportation (bus or otherwise).

Parent/Guardian Signature Date

I hereby authorize Stepping Stones to allow my child to participate in water activities.

Parent/Guardian Signature Date

A child who appears ill upon arrival shall not be admitted into the facility. When a child becomes ill at the center, the parent will be contacted and arrangements made for the child to be picked up immediately. At the time of registration, the parents should authorize the child's physician to accept all calls from the center's directors for emergency medical care.

Parent/Guardian Signature Date

I hereby authorize Stepping Stones to apply sunscreen and bug repellent to my child when venturing outdoors.

Parent/Guardian Signature Date

I hereby authorize Stepping Stones to permit photographs of my child for portfolio assessment, artwork, and publication purposes. I will not seek compensation for photos.

Parent/Guardian Signature Date

I hereby authorize Stepping Stones to post any necessary allergy information in my child's classroom.

Parent/Guardian Signature Date

I acknowledge that I have read the Stepping Stones parent handbook.

Parent/Guardian Signature Date

Certificate of Health

This child is medically **up to date** **not up to date** on immunizations. If not up to date, immunization(s) can be made in __________ months. __________________________ (child's name) has my permission to attend school.

I have examined this child and believe him/her to physically fit to participate in the normal activities in which children are involved, including outdoor play in suitable weather.

Are there any restrictions on normal physical activities indicated? **Yes** **No**
If yes, please specify: ____

Does the child have any chronic medical condition necessitating dietary supplements or restrictions?
Yes **No**
If yes, please specify: ____

Does the child have any known asthmatic problems? **Yes** **No**
If yes, special attention required: ____

Does the child have any known allergies? **Yes** **No**

Is this a medical allergy or preferred allergy? ______________________________________
If this is a medical allergy an action plan must be included on letter head from doctor's office.

______________________________ ________________
Physician's Signature **Date**

My child has been examined in the past year by a health care professional and is able to participate in the school program. Within the twelve months, I will obtain a health care professionals signed statement and submit it to the school.

______________________________ __________________
Parent Signature Date