

**MARK OF EXCELLENCE PRE SCHOOL
&
ACADEMY**

**29 GROVE STREET
STAMFORD, CT 06901
203-353-1503
Fax 203- 324-7334
WWW.MARKOFEXCELLENCEPA.ORG**

REGISTRATION BOOKLET

**DR. JOSEPH FORD
EXECUTIVE DIRECTOR**

**PHYLLIS T. CRAIG
DIRECTOR**

WELCOME TO EXCELLENCE

**A LOCAL PRE-SCHOOL WITH A GLOBAL MISSION
FOR EDUCATIONAL EXCELLENCE**

MARK OF EXCELLENCE EMERGENCY FORM

WE WILL NOT BE RESPONSIBLE FOR FALSE INFORMATION
PLEASE FILL OUT THIS FORM COMPLETELY.
MAKE SURE ALL INFORMATION IS CORRECT.

THIS FORM IS TAKEN WITH STAFF MEMBERS WHENEVER THE CHILD LEAVES
THE CENTER ON FIELD TRIPS, PLAYGROUND ETC.

CHILD'S NAME: _____ AGE _____ DOB _____

ADDRESS: _____

HOME PHONE NUMBER: _____ CELL _____

MOTHERS WORK NO. & ADDRESS: _____

FATHERS WORK NO. & ADDRESS: _____

EMERGENCY CONTACT PERSONS (2) PERSON SHOULD BE ABLE TO ACT ON
YOUR BEHALF IT YOU CANNOT BE REACHED.

NAME: _____ PHONE NO. _____
CELL NO. _____

ADDRESS: _____ RELATIONSHIP _____

NAME: _____ PHONE NO. _____
CELL NO. _____

ADDRESS: _____ RELATIONSHIP _____

ANY KNOWN ALLERGIES _____

IS CHILD ON REGULAR MEDICATION? _____

HOSPITAL PREFERENCE _____

CHILD'S DOCTOR: _____ PHONE _____

ADDRESS: _____

I AGREE THAT THE OPERATOR/STAFF MAY AUTHORIZE THE PHYSICAN OF
HIS/HER CHOICE TO PROVIDE EMERGENCY CARE FOR MY CHILD IN THE EVENT
THAT NEITHER I NOR THE FAMILY PHYSICIAN CAN NOT BE CONTACTED
IMMEDIATLEY.

DATE _____ SIGNATURE _____

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EMAIL AEDWARDS@MARKOFEXCELLENCEPA.ORG

PLEASE FILL OUT THIS APPLICATION COMPLETELY. ACCURATE INFORMATION IS NECESSARY SO THAT WE MAY BEST SERVE YOUR CHILD. IT IS YOUR RESPONSIBILITY TO NOTIFY US IMMEDIATELY OF ANY CHANGES.

DATE _____ (START DATE _____)

CHILD'S NAME _____

DOB _____ NICKNAME _____

PHONE NO. _____ E-MAIL _____

HOURS CARE IS NEEDED _____

WHO IS CHILD'S LEGAL GUARDIAN? _____

MOTHER'S NAME _____

FATHERS NAME _____

ADDRESS _____ PHONE _____

CITY _____ ZIP _____

MOTHERS' EMPLOYER & ADDRESS _____

MOTHER'S WORK NUMBER _____ CELL NO. _____

FATHER'S EMPLOYER & ADDRESS _____

FATHERS WORK NUMBER _____ CELL NO. _____

MEMBERS OF HOUSEHOLD & RELATIONSHIPS

WHO IS AUTHORIZED TO PICK YOUR CHILD UP FROM SCHOOL?

HAS YOUR CHILD EVER ATTENDED DAY CARE BEFORE? _____

IF YES, WHERE _____ **FOR HOW LONG** _____
MAY WE CONTACT THEM? _____ **YES OR NO** _____

REASON FOR LEAVING _____

PERSONAL HISTORY

|| **TYPE OF BIRTH** NORMAL _____ **PREMATURE** _____ **ANY COMPLICATIONS?** _____ ||
IS CHILD A GOOD CLIMBER? _____ **DOES CHILD SPEAK ANY OTHER**
LANGUAGE? _____ **IS THERE ANY FOODS YOUR CHILD CAN NOT**
EAT _____?

IS THERE ANYTHING WE CAN DO TO MAKE YOUR CHILD'S STAY HERE MORE ENJOYABLE? _____

IS THERE A PROBLEM WITH YOUR CHILD THAT WE SHOULD BE AWARE OF?

PLEASE BE AWARE THAT AT ANY TIME YOU MAY BE ASKED TO REMOVE YOUR CHILD IF HE OR SHE CONTINUES TO CAUSE HARM TO HIMSELF OR OTHER CHILDREN WITHOUT NOTICE.

PARENTS SIGNATURES _____ **DATE** _____

_____ **DATE** _____

CHILDS MEDICAL HISTORY

NAME

HAVE YOUR CHILD HAD	YES	NO	AGE	DESCRIBE OR COMMENT
MEASLES				
GERMAN MEASLES				
MUMPS				
CHICKEN POX				
WHOOPING COUGH				
DPHITHERIA				
IFLUENZA (FLU)				
MENINGITIS				
HIGH FEVERS				
ABSCESSED EARS				
ENCEPHALITIS				
ALLERGY				
CONVULSIONS				
INJURIES TO HEAD				
LEAD POISONING				
ANEMIA				
HOSPITALIZATIONS				
OPERATIONS				
OTHER INJURIES				

PERMISSION AGREEMENT

- A. I/WE GRANT PERMISSION FOR MY CHILD TO USE ALL OF THE PLAYGROUND EQUIPMENT AND PARTICIPATE IN ALL OF THE ACTIVITIES OF THE SCHOOL, UNLESS EXCEPTIONS ARE NOTED HERE _____
- B. I/WE GRANT PERMISSION FOR MY CHILD TO LEAVE THE SCHOOL PREMISES UNDER THE SUPERVISION OF A STAFF MEMBER FOR NEIGHBORHOOD WALKS OR ON FIELD TRIPS IN AN AUTHORIZED VEHICLE.
- C. I/WE GRANT PERMISSION FOR MY CHILD TO BE INCLUDED IN EVALUATIONS AND CONNECTED WITH THE DAY CARE CENTER'S PROGRAMS.
- D. I HEREBY GRANT PERMISSION FOR THE STAFF TO TAKE WHATEVER STEPS MAY BE NECESSARY TO OBTAIN EMERGENCY MEDICAL CARE IF WARRANTED. THESE STEPS MAY INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:
1. ADMINISTER FIRST AID.
 2. ATTEMPT TO CONTACT PARENT OR GUARDIAN.
 3. ATTEMPT TO CONTACT THE CHILD'S PHYSICIAN.
 4. ATTEMPT TO CONTACT THE PARENT THROUGH ANY OF THE PERSONS LISTED ON THE EMERGENCY INFORMATION PAPER COMPLETED FOR THE CENTER. (NOTE IT IS THE PARENT'S RESPONSIBILITY TO KEEP THIS INFORMATION UP TO DATE.)
 5. IF WE CANNOT CONTACT THE PARENT OR THE CHILD'S PHYSICIAN, WE WILL DO ANY OR ALL OF THE FOLLOWING:
 - A. CALL ANOTHER PHYSICIAN
 - B. CALL A AMBULANCE
- C. HAVE THE CHILD TAKEN TO AN EMERGENCY HOSPITAL IN THE COMPANY OF A STAFF MEMBER; STAFF VEHICLE; OR PROGRAM VEHICLE.

ANY EXPENSES INCURRED UNDER NO. 5 ABOVE, WILL BE BORNE BY THE CHILD'S FAMILY.

THE SCHOOL WILLNOT BE RESPONSIBLE FOR ANYTHING THAT MAY HAPPEN AS A RESULT OF FALSE INFORMATION GIVEN AT TIME OF ENROLLMENT.

THE SCHOOL WILL NOT ASSUME RESPONSIBILITY FOR A CHILD WHO AS NOT SIGNED IN WHEN HE/SHE ARRIVES FOR THE DAY.

SIGNED: _____ DATE: _____