



Dear Parents/Guardians,

Welcome to the Kearns-Saint Ann Early Childhood Center and the Kearns-Saint Ann Catholic School community! The enclosed packet of information must be completed and given to the Director prior to starting in our center. In the packet you will find our parent handbook and contract, emergency contact form, medical release form, automatic-withdrawal and agreement to pay form, and photography/video release form. Please read through the parent handbook as it is a guide to our policies and procedures. Don't forget to bring a copy of current immunizations, birth certificate, and baptismal record (if applicable). Please call with questions.

We look forward to having you in our KSA ECC Family!

Blessings,

Kaitlin Dignam

Director of Kearns-Saint Ann Early Childhood Center

**KEARNS-SAINT ANN
Early Childhood Center
REGISTRATION FORM**

START DATE

Parent or Guardian's Name (please print) _____

Guardian 1 email: _____ Guardian 2 email: _____

Address: _____ City: _____ Zip _____

Child's Name: _____ D.O.B _____

Child's Name: _____ D.O.B _____

Child's Name: _____ D.O.B _____

Registration Fee \$100/child \$ _____

8 weeks – 2 yr
7:00 a.m. – 6:00 p.m. \$1,040.00/month \$ _____

2 yr old
7:00 a.m. - 6:00 p.m. \$930.00/month \$ _____

3 yr old Pre-School
7:00 a.m. - 6:00 p.m. \$870.00/month \$ _____

CHECK # _____
RECEIPT# _____

TOTAL \$ _____

PAYMENT \$ _____

BALANCE DUE \$ _____

Parent or Guardian Signature:

_____ Date _____

Phone # Work: _____ Home: _____ Cell: _____

Kearns-Saint Ann Early Childhood Center Emergency Contact Form

Mark One: Full Time Part Time

Name: _____ Birth Date: _____ Enrollment Date: _____

Home Address: _____ Zip: _____ Home Phone: _____

Student Lives With: Both Parents Mother Father Other Student's Grade: __ Sex: _____

Father/Guardian's Name: _____ Cell #: _____

Employer: _____ Work Phone: _____

Mother/Guardian's Name: _____ Cell #: _____

Employer: _____ Work Phone: _____

Persons designated to pick up child:

	Name	Relationship	Work/Home Phone	Cell
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Persons who may be called in case of illness or emergency if parent cannot be reached:

	Name	Relationship	Work/Home Phone	Cell
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Child's Physician: _____ Phone: _____

Describe any pertinent social information or special needs of the child:

Describe any physical or medical problems of the child, i.e. seizures, asthma, diabetes, allergies, heart disease, respiratory illness, drug reaction, speech difficulties, etc.:

Give instructions for the care of the above-mentioned problems:

In case of serious emergency or illness, when a parent cannot be reached immediately, I hereby authorize the childcare giver to obtain emergency medical care, i.e. physician, dentist, paramedics or other authorized emergency agents.

Signature of Parent or Guardian

Date: _____



MEDICAL RELEASE FORM

This is a medical release for a minor child, which may permit treatment in an emergency. While there are other methods for hospitals and other medical facilities to obtain permission to treat a minor child in the absence of parental consent, it is a good idea to have one of these permission slips on file in the office, in the teacher's backpack, in the child's doctor's office, as well as the nearest hospital to be sure there is no delay in case of an emergency.

The information must be updated annually or more often if the information contained herein changes.

Please print the following information.

I, _____ Parent or Legal Guardian of _____,

a minor child, hereby authorize any medical or surgical treatment that may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor. I agree to hold the physician or hospital treating the above-mentioned minor harmless. I also give the hospital permission to release information to my insurance company(s) and give them permission to collect payment from said insurance company(s).

Child's Name _____ Grade _____ Date of Birth _____

Medication currently taking: _____

Regular Physician: _____ Phone Number: _____

Insurance Co: _____ ID Number: _____

Home Address: _____ Home Phone: _____

Father's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Describe in full any allergies (drug, food, insect bites, etc.) or limitations on physical activity,

Drug Allergies: _____

Food Allergies: _____

Other Allergies: _____

Physical Limitations: _____

Name of person other than guardian to contact in case of an emergency:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Signature of Parent/Legal Guardian _____ Date: _____

