

SPROUTS

ADMISSION PACKET

GROWING
CHILDREN
WHO LOVE
GOD
LOVE PEOPLE
& LOVE
LEARNING

STUDENT INFORMATION

Student's full name: _____
(last) (first) (middle)

Preferred name: _____ ☐ Male ☐ Female Birthdate: ____ / ____ / ____

Address: _____
(street) (city) (state) (zip)

Phone: (____) _____ - _____ For school year: ____ - ____

PARENT INFORMATION

Father / Legal Guardian Information (*please circle one*)

Full name: _____

Address: _____
(street) (city) (state) (zip)

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Driver's License No. _____ State: _____

Mother / Legal Guardian Information (*please circle one*)

Full name: _____

Address: _____
(street) (city) (state) (zip)

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Driver's License No. _____ State: _____

DESIGNATED CONTACTS & PICKUPS

If I cannot be reached in the event of an emergency, an illness, or my child is left after school hours, **SPROUTS** has permission to contact the following person(s) to pick up my child. **NOTE: Please list these contacts in the order you prefer us to call them. You must list at least ONE contact. ALL information must be provided. Please use only LOCAL contacts who would be available. All addresses must be PHYSICAL addresses and not post office boxes.**

1. Name: _____ Relationship: _____
Address: _____
(street) (city) (state) (zip)
Telephone: _____ Cell Phone: _____
Driver's License No.: _____ State: _____
2. Name: _____ Relationship: _____
Address: _____
(street) (city) (state) (zip)
Telephone: _____ Cell Phone: _____
Driver's License No.: _____ State: _____

(Please list any additional contacts on reverse side.)

Signature of Parent / Legal Guardian

Date

Name of Student: _____ Date of Birth: _____

PHYSICIAN INFORMATION

Child's Physician: _____

Physician's Address: _____

City: _____ State: _____ ZIP: _____

Physician's Telephone: _____

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency, accident, or serious illness in which medical attention/treatment is required for my child, I do hereby authorize that qualified and licensed medical personnel give treatment. I understand that I will be contacted first. If **SPROUTS** is unable to reach me, my signature below authorizes **SPROUTS** to exercise their own judgment in contacting my child's physician or make arrangements as deemed necessary to have my child transported to the emergency medical care facility listed below (*the facility of choice is **not** guaranteed*). I understand and agree that all expenses incurred in treatment will be assumed either directly by me or by my insurance company. I will not hold **SPROUTS** and **RHEA'S MILL BAPTIST CHURCH** responsible for any emergency, accident, or serious illness that requires the use of this Emergency Medical Authorization.

Name of preferred Emergency Medical Care Facility: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Name of Insured: _____

Insurance Company: _____

ID #: _____ Group #: _____

Telephone: _____

PERMISSION

*Please check all that apply:*Permission to use your child's photo for -advertising/media purposes: ☐ Yes ☐ No -scrapbooks & in-class projects: ☐ Yes ☐ NoPermission to attend class fieldtrips [4th years only]: ☐ Yes ☐ NoPermission for water play activities: -sprinkler play ☐ Yes ☐ No -wading pool ☐ Yes ☐ No -water table ☐ Yes ☐ No

ALLERGIES & OTHER IMPORTANT INFO

Does your child have any allergies? ☐ Yes ☐ No

If so, what?: _____

How are allergies manifested (rash, swelling, upset stomach, etc.)? _____

Does your child have any physical handicaps? ☐ Yes ☐ No

If so, what? _____

List any dietary restrictions: _____

Is child potty trained? ☐ Yes ☐ No Any assistance needed? ☐ Yes ☐ No Explain: _____

List any routine or "as needed" medications taken by your child: _____

Please describe your child's overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please give any additional information you think may be important for us: _____

Name of Student: _____ Date of Birth: _____

HEALTH REQUIREMENTS

ADMISSION REQUIREMENT: One of the following must be presented when your child is enrolled in **SPROUTS** or within one week of admission. Check to indicate the option you select:

☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above-named child within the past year and find that he/she is physically able to participate in school activities.

Date: _____ Signature of Health-Care Professional _____

☐ A signed and dated copy of a health-care professional's statement is attached. (Must be stamped with address of health-care professional.) If child is age four and over, a copy of the latest hearing and vision testing is also attached.

☐ **PARENT'S STATEMENT:** My child has been examined within the past year by a health-care professional and is physically able to participate in school activities. I will obtain a health-care professional's signed statement within 30 days of admission, and will submit it to **SPROUTS**.

Name and address of health-care professional: _____

☐ Medical diagnosis and treatment conflict with the tenets and practices of our recognized religious organization, to which I adhere to or am a member. I have attached a signed and dated affidavit stating this fact.

IMMUNIZATIONS	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Booster	Date/Booster
DTP/DTaP/DT					
IPV or OPV					
MEASLES/MUMPS/ RUBELLA					
HIB					
HEPATITIS A					
HEPATITIS B					
PCV7					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____		
VARICELLA (see below)					

Varicella (Chickenpox) vaccine is not required if your child has already had the disease. If your child has had Chickenpox, please complete the following statement: My child had Varicella Disease (Chickenpox) on or about _____ and does not need the Varicella Vaccine.

Date: _____ Parent Signature _____

Date: _____ Signature of Health-Care Professional _____

Immunizations must be signed or rubber-stamped by physician or other health-care professional.

Hearing Screening (required for all four-year-olds)		Date		Signature
Hz	1000	2000	4000	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R				
L				
Vision Screening (required for all four-year-olds)		Date		Signature
R20/		L20/		<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Name of Student: _____ Date of Birth: _____

Please circle your child's t-shirt size: 2T 3T 4T 5T 6 7

SCHOLASTIC INFORMATIONHas your child participated in preschool before? ☐ Yes ☐ No

School: _____ Class: _____

School: _____ Class: _____

Describe your expectations of **SPROUTS** in regard to your child. _____

PREFERENCES

Please check the appropriate class. The child must turn the age of the class by September (*i.e. must be 4 years old by September 1 to enroll in the Pre4 class*). **Children in Pre3 or Pre4 classes must be potty trained.**

Age on September 1: _____

☐ Pre1 _____ T/R☐ Pre2 _____ T/R☐ Pre3 _____ T/R ☐ Pre3 _____ T/W/R☐ Pre4 _____ T/R ☐ Pre4 _____ T/W/RIs your child potty trained? ☐ Yes ☐ No ☐ PartiallyDoes child need assistance using the restroom? ☐ Yes ☐ No

Explain: _____

Signature of Parent / Legal Guardian

Date

Office Use Only:☐ Enrollment

Date: _____

☐ Registration Fee

Date Paid: _____

Check #: _____ Amt: \$ _____

☐ Supply Fee

Date Paid: _____

Check #: _____ Amt: \$ _____

Payment Options:

☐ Full Payment

Date Paid: _____

Check #: _____ Amt: \$ _____

☐ Monthly Payments

Teacher's Name: _____ Room #: _____

☐ M ☐ F City: _____ Date: _____ Check # _____ Amt \$ _____

Name of Student: _____ Date of Birth: _____

STUDENT INFORMATION & CALL IN CODE

Name of Student: _____ Class: _____

Who will primarily bring the child to school? _____

Who will primarily pick up the child from school? _____

CALL-IN PASSWORD

The call-in password is used for the protection of your child. In the event you need to call **SPROUTS** with instructions for your child's release to any individual other than yourself, we will require this call-in password to verify that you are the child's parent.

Call-In Password: _____ Reminder Question: _____

INFORMATION SOURCE

How did you hear about **SPROUTS**?

- ☐ Website ☐ Newspaper ☐ Church Newsletter ☐ Private School Fair ☐ Yellow Pages
☐ Friend ☐ Sign ☐ Other: _____

NON-DISCRIMINATION POLICY

SPROUTS admits students of any race, color, national or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national, or ethnic origin in administration of its educational policies, admission policies, scholarship and loan programs, athletic, or other school-administered programs.

FINAL INSTRUCTIONS

This **Admission Packet** must be completed in its entirety for each student seeking admission to **SPROUTS**. It should be submitted in person or mailed to **SPROUTS**. All students are admitted on a 'first come, first serve' basis.

PARENT STATEMENT

We understand that admission to **SPROUTS** is subject not only to space available but also to the **SPROUTS** policies, procedures, and guidelines. We further understand and acknowledge that continued enrollment of our child shall be subject to the payment of all fees and charges. We have also read and agree with all of the terms and policies in the Parent/Student handbook.

Signature of Father / Legal Guardian

Date

Signature of Mother / Legal Guardian

Date

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conveniently located on the Prosper-McKinney line near the corner of Frontier & Custer
Sprouts is a ministry of Rhea's Mill Baptist Church

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