Safe Site Educational Center

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Mixed Pre-K, Early Pre-K & Pre-K

☐Birth Certificate ☐Immunizations ☐Physical ☐Dental ☐ASQ Consent ☐Health Screening ☐Application Complete

Child's Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ Gender: ☐Female ☐Male

Father's Full Name: _____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email address: _____

Work Place: _____ Work #: _____ Driver's License #: _____

Mother's Full Name: _____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email address: _____

Work Place: _____ Work #: _____ Driver's License #: _____

Race (check only one): ☐American Indian/Alaskan Native ☐Native Hawaiian or other Pacific Islander

☐Caucasian (White) ☐African American ☐Asian ☐Other _____

Ethnicity: Hispanic or Latino ☐Yes ☐No

Language Spoken at Home: Primary _____ Secondary _____

Bi-lingual ☐Yes ☐No What other languages does your child speak? _____

How well does your child speak english? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

Do you have any concerns about your child's overall health and development? ☐Yes ☐No

If yes, please describe your concerns: _____

Child's Full Name: _____ Date of Birth: _____

The following persons *are authorized* to pick up my child:

All persons picking up any child must be at least 18 years old and have a picture ID with their date of birth listed.

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

Name: _____ Driver's License #: _____

Relationship to child: _____ Phone #: _____

*** List any person that *cannot* pick up your child:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Emergency Contacts

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Name: _____ Relationship to child: _____

Home #: _____ Cell #: _____ Work #: _____

Parent/Guardian Signature: _____ **Date:** _____

Allergies and/or Medical Conditions

List any allergies your child has: (foods, medications, etc.)

1. _____ 2. _____ 3. _____

List any medical conditions/health issues your child has:

1. _____ 2. _____

Does your child have any special dietary conditions? ☐**Yes** ☐**No**

If yes, please describe dietary condition(s):

_____

Consent for Emergency Treatment, Permission to Emergency Transport & Hospital Preference

In such a case as necessary, I hereby give my consent for emergency medical treatment and transportation for my child : Child's Name: _____ Date of Birth: _____

I understand that a conscientious effort will be taken to contact me, but if this is not possible my child may be treated and transported to an emergency care facilty.

Preferred Hospital: _____ Phone #: _____

Physician's Name: _____Phone #: _____

Parent/Guardian Signature: _____ **Date:** _____

***Safe Site is not responsible for any costs incurred for emergency treatment and/or emergency transportation!

Permission to Obtain and/or Reveal Confidential Information

I (parent/guardian), _____ give Safe Site consent to obtain from or give the following agencies and/or persons pertinent social services, medical, or other information about myself and/or child _____ for whom I am legally responsible.

In granting such permission, I understand that all information will remain confidential and that such information will be used to benefit the child named above. This consent is valid for one year from the date this is signed.

List any agencies and/or persons that will be visiting your child while in our care.

Name of Agency and/or Person: _____ Phone #: _____

Name of Agency and/or Person: _____ Phone #: _____

I release Safe Site and the above mentioned agencies/persons from any legal liability for disclosing or acquiring information about myself and/or child.

Parent/Guardian Signature: _____ **Date:** _____

Requirements for Enrollment

The following documents must be completed and/or turned in prior to the first day of Pre-K.

☐Completed Pre-K Packet ☐Copy of Birth Certificate ☐Copy of Social Security Card

☐Up-to-date Immunization Records ☐Completed Physical Form ☐Completed Dental Form

☐Elementary School that you expect your child to attend for kindergarten: _____

Consent for Health Screenings, Observations and Assessments

Child's Name: _____Date of Birth: _____

The screenings listed below are a major part of our Pre-K Program and will help us to plan for your child's success while at Safe Site. If you agree to these screenings, please check the boxes that you are giving consent for.

☐Vision ☐Hearing ☐Height ☐Weight ☐ Observations ☐Developmental Screenings/Assessments

Parent/Guardian Signature: _____ **Date:** _____

Permission to Leave Facility

I give my permission for my child to be transported to field trips, go on walks off of Safe Site premises, and/or be transported to/from school in a company owned vechilce. I understand that all staff driving the company owned vehicles have a current and valid NM drivers licence and that the company owned vehicles are fully insured.

Parent/Guardian Signature: _____ **Date:** _____

Rates and Schedules

The NM ***Free*** Pre-K Program schedule is as follows:

Monday through Thursday 8 am to 2 pm

***If you need child care services for your child before and/or after Pre-K hours or on Fridays the fee is $60 per week and is due in advance. You are required to let the front office personnel know if you decide to use this service.

Acknowledgement

I have read Safe Site's Family Handbook and Discipline Policy and agree to comply with Safe Site's Policies and Procedures. I understand that Safe Site reserves the right to change its policies and procedures with as much notice as possible to families. I have reviewed the rates and fees schedule, along with other services provided by Safe Site and am willing to abide by the policies/procedures and I agree to fulfill my financial obilgations. Safe Site's staff will make every effort to ensure the safety of my child and I will not hold Safe Site responsible for any injury or accident that may result on or off the child care grounds/facilty.

Parent/Guardian Signature: _____ **Date:** _____

Official Use Only: Date of Enrollment _____ Date of Withdrawal: _____

Health Screening Verification

Child's Name: _____ Date of Birth: _____

My child has had a well-child check-up in the past 12 months. (Including immunizations)	Yes	No
My child has had a dental screening in the past 12 months.	Yes	No
My child has had a vision screening in the past 12 months.	Yes	No
My child has had a hearing screening in the past 12 months.	Yes	No

I have received and/or been offered a Community Resource List that includes well-child physicians, dentists, vision and hearing providers.

Parent/Guardian Signature: _____ **Date:** _____

ASQ & ASQ-SE Consent Form

Child's Name: _____ Date of Birth: _____

Child's Primary Physician: _____ Phone #: _____

The first five years of life are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/ monitoring program.

☐ I ***do wish*** to have my child participate in the screening/monitoring program-Ages and Stages Questionnaires (ASQ & ASQ-SE).

☐ I ***do not wish*** to have my child participate in the screening/monitoring program-Ages and Stages Questionnaires (ASQ & ASQ-SE).

Was your child born 3 or more weeks premature, if so at how many weeks: _____

Parent/Guardian Signature: _____ **Date:** _____

Dear Family Member:

The New Mexico PreK Program, administered by the New Mexico Early Childhood Education & Care Department (ECECD) and the Public Education Department (PED) along with our Contractor, UNM Continuing Education Early Childhood Services Center is asking permission to take photographs and/or to videotape your child during their time in the NM PreK classroom.

In order to do this, we must first have parental/guardian permission to take photographs of or film of your child. Copies may be used by ECECD, PED or UNM-CE in ongoing research, reports, marketing materials to promote New Mexico PreK, etc. Pictures/film of your child may be used for training purposes or in future professional publications.

For all of the above, we require your permission. **If you do not want your child's photograph taken at all, you have the option of not granting your permission or not signing this authorization form.**

Thank you for your cooperation and support.

The undersigned parent or legal guardian does hereby consent for their child to be photographed or videotaped, and does hereby authorize the State of New Mexico or its contractor, UNM- Continuing Education Early Childhood Services Center staff to take photographs or videotapes, which will be used for research, training, brochures, reports, marketing and the like.

The undersigned does hereby release the State of New Mexico or its contractor, UNM-CE Early Childhood Services Center staff from any and all claims for damages for libel, slander, invasion of the right of privacy, or any claims based on the use of said material. This includes compensation of any sort now or in the future, in the event that your child's photograph or videotape is used in any of the aforementioned materials including professional publications, marketing, training, reports, etc. developed by NM PreK and their contractor, UNM Continuing Education Early Childhood Services Center.

Please check the boxes ☐ that apply.

- ☐ I authorize my child to be videotaped and/or photographed and the use of my child's image for publication in reports, professional articles and books, professional development and promotional/marketing materials.
- ☐ I do not want my child to be videotaped or photographed.

I CERTIFY all of the following:
This form has been explained to me and/or I have read the contents of this form or the contents have been read to me. I understand the contents of this form and/or the explanation of the contents of this form. All blanks or statements requiring insertion or completion were filled in and all items not applicable were stricken before I signed.

_____
NAME OF CHILD (Please print)

_____ _____
NAME OF PARENT/GUARDIAN (Please print) DATE

_____ _____
ADDRESS PHONE

_____
CITY, STATE, ZIP CODE

_____
SIGNATURE OF PARENT/GUARDIAN

Home Language Survey*

☐ Check here if the child's parents or legal guardians decline to provide information for this survey.

A. What language do family members use when speaking to the child in the home?

	1	2	3	4	5
	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

(write in home language: _____)

B. What language does the child use when speaking to family members in the home?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

C. What language does the child use when speaking to other children in the classroom?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

D. What language does the child use when speaking to the teachers?

N/A	1	2	3	4	5
Not applicable	only English	mostly English but sometimes home language	both equally	mostly home language but some English	only home language (not English)

Sum of circled numbers / Number of questions answered = _____

_____ / _____ = _____

If this value is 2 or greater and the child is in a preschool 3, pre-K4, or kindergarten class, use Objectives 37 and 38.

***These research reports helped guide our thinking in the development of the "Home Language Survey":**

Aikens, N. L., Caspe, M. S., Sprachman, S., López, M. L., & Atkins-Burnett, S. M. (June 2008). *Paper Symposium: Development of a language routing protocol for determining bilingual Spanish–English speaking children's language of assessment.* Biennial Head Start Research Conference. Washington, DC.

Puma, M., Bell, S., Cook, R., Heid, C., López, M. L., et al. (2005). *Head Start impact study: First year findings.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Gutiérrez-Clellen, V. F., & Kreiter, J. (2003). Understanding child bilingual acquisition using parent and teacher reports. *Applied Psycholinguistics, 24*(2), 267–88.

BILLING

Child's Name: _____ **Date of Birth:**_____ **Parents Name(print):**_____

Payment Agreement – Must be signed upon registration. *Make selections below, one under Billing Plan and one under Payment Schedule.*

Billing Plans / Payment – Multiple billing plans are available. There is **NO REDUCTION IN RATES** for closed days, holidays or sick days (not applicable to Hourly and Daily billing plans). Any hours over and above allocated hours will be billed at the hourly rate. A two-week notice must be submitted in writing to the Director for any requests to change billing plans, and upon Director approval a new billing/payment agreement will be completed and signed. *Note: for hourly rates, minutes 1-30 are billed at half hour rate, minutes 31-59 are billed at a full hour rate.*

PREFERRED METHOD OF PAYMENT: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

Select One Billing Plan	PLAN	COST	NOTES
☐	**Full Time**	$128.63 per week	6 hours or more per day OR 6:00 am to 6:00 pm (5% discount each additional child)
☐	**Part Time**	$117.90 per week	Up to 5 hours per day
☐	**Before & After School / School Age Children**	$60.00 weekly Summer rate $80.00 weekly	Summer rate applies to the months of June, July
☐	**Hourly / Drop In**	$6.00 per hour	2 hours minimum per day
☐	**Daily**	$30.00	5 hours minimum
☐	**State Funded** (CYFD Placement Agreement)	Co-Payment (as determined by CYFD)	Due by the 15th of each month.
☐	**Transportation Fee**	☐ $3.00 each way ☐ OR $30.00 per month	Transportation is for regular school schedules **ONLY.** If your child misses the center school bus there will be a $3.00 transportation fee AND a two-hour minimum hourly rate.

Select One Payment Schedule	PAYMENTS
☐	**Weekly Payments:** Due one (1) week in advance of services rendered and payable every Friday unless alternate arrangements made *in advance and approved by the Director.* Hourly billing plan must give one (1) week deposit and balance to be paid every Friday by 6:00 pm closing (credits/overpayments will be carried to the following week)
☐	**Monthly Payments:** Due 1st Monday of the month. Must be approved by the Director.
☐	**15th of each month: ONLY State Funded** accounts are eligible for this schedule.

LATE & PAST DUE ACCOUNTS: $10.00 LATE FEE will be applied to all past due accounts. After three days past due, account accrues a daily late fee of $3.00 per day in addition to the initial $10.00 late fee. Child care services will not be rendered and your child will not be accepted until past due accounts are paid in full. Multiple/repeated late payments will result in disenrollment. Parent or legal guardian agrees to pay any costs and fees associated with collection efforts (including and not limited to attorney's fees and/or court costs). Accounts with history of past due, late payments, or NSF payments will not be eligible for the Monthly Payment Schedule and must be paid on the Weekly Payment Schedule. **EXPIRED CYFD PLACEMENT AGREEMENT:** Parent or legal guardian will be responsible for charges that accrue on an account with an expired placement agreement (State Funded).

Signature: _____ **Date:** _____

Safe Site Child Development, Inc.

Child Health Record-Screening, Physical Examination/Assessment

Child's Name: _____ DOB: _____ Gender: F_____ M _____ Date: _____

Parent/Guardian Name: _____

Provider Information

Provider Name: _____ Provider Phone: _____

Provider Address: _____ City/State/Zip: _____

Physical Assessment

	Normal	Abnormal	Refer	Not Examined
General Appearance				
Posture, Gait				
Head				
Skin				
Eyes				
Ears (external Canal)				
Nose, Mouth				
Pharynx				
Teeth				
Heart				
Lungs				
Abdomen(hernia)				
Bones, Joints				
Muscles				
Neurological Gross Motor Fine Motor				
Glands – Lymphatic/Thyroid				
Muscular Condition				
Abnormal Conditions:				
Asthma/Allergies:				
Current Medications:				

Child Health Status

	Yes	No
Child is up-to-date on schedule of age appropriate preventative and primary care?		
Child needs to establish the following services:		
• Well Child Care		
• Immunizations Update		
• Routine Dental Care		
• Mental Health		
• Child has acute and chronic conditions:		
• Is receiving adequate ongoing care		
• Needs to establish services		
• Needs to update or re-establish services		
Child has suspect or significant concerns. Explain:		
Child's status was determined by:		
• Parent Report		
• Medical History		
• Today's Exam		

Additional provider comments:

Standard Tests & Measurements

	Normal	Abnormal	
Blood Pressure _____/_____			HGB _____ or HCT_____
Height _____inches			Lead Test Results: _____ug/dl
Weight _____lbs. _____oz.			Vision Test Results: _____
Other:			Hearing Test Results: _____

Overall Results

	Normal	Abnormal		Yes	No
Overall Impression of Health			Follow-Up or Referral Needed		

Provider Signature: _____ Date: _____

Safe Site Child Development, Inc.

Child Oral Health Condition

Child's Name: _____ DOB: _____ Gender: F_____ M _____ Date; _____

Dental Provider Information

Dental Provider Name: _____ Dental Provider Phone: _____

Dental Provider Address: _____ City/State/Zip: _____

Form Completed by: _____

Type of Exam: Screening _____ Examinat on_____

Follow Up Date: _____

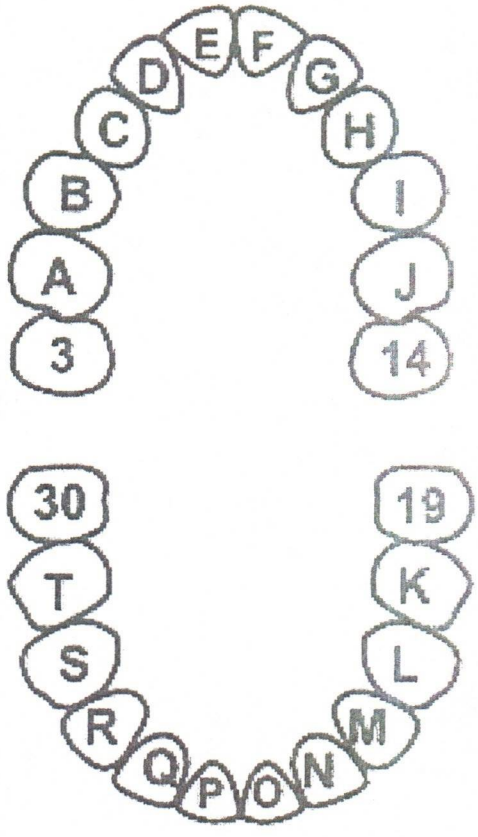
Referral Date: _____

Flossing Frequency: N/A _____

Never _____ Daily _____ Weekly _____ Occasionally _____

Gum Condition:

Normal _____ Swollen _____ Infected _____ Bleeds Easily____



Dental Needs: No Needs _____

Treatments _____ Cleaning _____ Fluoride Supplement _____

Oral Hygiene Instructions _____

Other: _____

Treatment: Received Treatment____Date: _____

Fluoride Supplement _____ Pulp Therapy _____ Cleaning ____

Extraction _____ Restoration _____

Oral Hygiene Instructions _____ Other (please explain): _____

_____

Provider Setting: Doctor/Clinic _____

Home _____ Employment _____ School _____ Other _____

Number of times per day child brushes teeth: _____

Dental Provider Signature: _____ Date: _____

Comments: _____

_____

_____