Parent/Guardian Information

Registration Date: ____________

Mother/Guardian

First Name __________________________ **M.I** ____ **Last Name**_________________________________

Address: ____

Occupation: _______________________________ **Cell Phone:** _________________________________

Employed By: _____________________________ **Office Phone:** ________________________________

Work Address: ____________________________ **Work Hours:** _________________________________

Email: ___________________________________ **Driver's License#:** ____________________________

☐ **Custodial Parent (If married, mark both parents)**

Marital Status ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Other:** _________

Father/Guardian

First Name __________________________ **M.I** ____ **Last Name**_________________________________

Address: ____

Occupation: _______________________________ **Cell Phone:** _________________________________

Employed By: _____________________________ **Office Phone:** ________________________________

Work Address: ____________________________ **Work Hours:** _________________________________

Email: ___________________________________ **Driver's License#:** ____________________________

☐ **Custodial Parent (If married, mark both parents)**

Marital Status ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Other:** _________

Child Information

First Name __________________________ **M.I** ____ **Last Name**_________________________________

Address: ____

Date of Birth: ________________________________ **Age:** ________ **Gender:** ☐ **Male** ☐ **Female**

Pediatricians Name: ___________________________ **Phone #:** __________________________________

Address: ____

List any medical conditions, allergies, medication and/or special attention you child may require

____

Child Information – Continued

First Name ___________________________ **M.I** ____ **Last Name**__________________________________

Address: ____

Date of Birth: _________________________________ **Age:** ________ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: ____________________________ **Phone #:** ___________________________________

Address: ____

List any medical conditions, allergies, medication and/or special attention you child may require

____

Child Information

First Name ___________________________ **M.I** ____ **Last Name**__________________________________

Address: ____

Date of Birth: _________________________________ **Age:** ________ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: ____________________________ **Phone #:** ___________________________________

Address: ____

List any medical conditions, allergies, medication and/or special attention you child may require

____

Child Information

First Name ___________________________ **M.I** ____ **Last Name**__________________________________

Address: ____

Date of Birth: _________________________________ **Age:** ________ **Gender:** ☐ **Male** ☐**Female**

Pediatricians Name: ____________________________ **Phone #:** ___________________________________

Address: ____

List any medical conditions, allergies, medication and/or special attention you child may require

____

Emergency Contacts & Authorized Pickup Persons

1st Contact/Pickup

Name: ____ **Phone#:** ______________________________

Relationship to Child: __________________________

- [ ] **Able to pick up all children in the family**
- [ ] **Not able to pick up the following children:** ____

2nd Contact/Pickup

Name: ____ **Phone#:** ______________________________

Relationship to Child: __________________________

- [ ] **Able to pick up all children in the family**
- [ ] **Not able to pick up the following children:** ____

3rd Contact/Pickup

Name: ____ **Phone#:** ______________________________

Relationship to Child: __________________________

- [ ] **Able to pick up all children in the family**
- [ ] **Not able to pick up the following children:** ____

4th Contact/Pickup

Name: ____ **Phone#:** ______________________________

Relationship to Child: __________________________

- [ ] **Able to pick up all children in the family**
- [ ] **Not able to pick up the following children:** ____

Financial Agreement

1. **Tuition is billed weekly and payment is due on the first day of each week. You may elect to pay monthly in advance or bi-weekly. A $25 late fee will be assessed if payment is not received when due.**
2. **A $25 fee is assessed for returned checks.**
3. **If two or more children from the same immediate family are enrolled, a 10% discount will be given on the least expensive tuition.**
4. **Registration fee for each school year is $100 per family and is due at time of application for new or returning students. Registration fee is not refundable.**

Additional Comments & Information

Is there any other information that would be helpful to our management and teaching staff?

____

____

Parents Signature: ______________________________________ **Date:** ____________________

CDC/SGH# or name:____________________

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):________________

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

---

Medical Information

Is child allergic to food or other substances? ☐ **No** ☐ **Yes** **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** **If yes**, specify procedure:
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Additional comments:
Other special instructions:

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**

GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR ENTRY

Child Care or Preschool (birth – 5 years)

Requirements by age at entry and on a continuing review status. Vaccines must follow minimum intervals and ages to be valid. A 4-day grace period applies in most situations.

Vaccine	2 Months	4 Months	6 Months	12 Months	15 Months	18+ Months
Hepatitis B (Hep B or HBV)	**Hep B 1*** (see pg. 2)	**Hep B 2**	**Hep B 3** (received at 24 weeks of age or older and by12 mos of age)		**Documented 3 or 4 doses** Note: If Hep B #3 was given before 24 weeks of age, a 4th dose is needed.	
Diphtheria, Tetanus, and Pertussis	**DTaP 1**	**DTaP 2**	**DTaP 3**	---	**DTaP 4**	**Documented 4 doses**
***Haemophilus influenzae* type b (Hib)**	**Hib 1**	**Hib 2**	**Hib 3**** (see pg.2)	---	**Hib 4**** (see pg. 2)	**Documented 3-4 doses**
Poliomyelitis (Polio) (IPV or OPV)	**Polio 1**	**Polio 2**	---	**Polio 3**	**Documented 3 doses**	
Measles, Mumps and Rubella (MMR)	---	---	---	**MMR 1**	**Documented 1 dose** Note: MMR and Varicella must be given on the same day or at least 28 days apart	
Varicella (chickenpox) (VAR)	---	---	---	**VAR 1**	**Documented 1 dose** Note: MMR and Varicella must be given on the same day or at least 28 days apart	
Hepatitis A (Maricopa County only)	---	---	---	**Hep A 1*****		**Hep A 2** (due 6 months after dose 1)
Summary of vaccines required for 15 months to Pre-kindergarten	All of these doses are required at 15 months of age and older: **3 Hep B, 4 DTaP, 3 Polio, 1 MMR, 1 Varicella, *and* 3-4 Hib or 1 Hib** dose given at/after 15 months. ****2 doses of Hepatitis A are required for children 1-5 years old in Maricopa County only, but are recommended in all other counties.*					

Please see reverse for additional information and exceptions and conditions to the rules.

Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120
Phoenix, AZ 85007 • (602) 364-3630

Last revised: October 2018

GUIDE TO ARIZONA IMMUNIZATIONS REQUIRED FOR ENTRY

Child Care or Preschool

The laws and rules governing child care and preschool immunization requirements are Arizona Revised Statutes §15-884; and Arizona Administrative Code, R9-5-305 & R9-6-701–708. Please review the child care requirements in Table 7.1 and "catch-up" schedule in Table 7.2, located in R9-6-701-708.

Students must have proof of all required immunizations in order to attend child care or preschool. Parental recall or verbal history of any disease is not accepted; therefore these students must submit an ADHS medical exemption form. **Specifically with varicella (chickenpox), measles, or rubella disease a medical exemption with attached laboratory evidence of immunity is required**.

A child who is missing vaccines required for his age can start child care but must get a dose of each vaccine due within 15 days of enrollment and bring a copy of the immunization record completed by the clinic to the child care facility. **After 15 days, the child may not attend child care without documentation that the child has received the required vaccinations.**

Arizona law allows child care immunization exemptions for medical reasons, lab evidence of immunity, and religious beliefs. For further information and guidance please review the Arizona Immunization Handbook for Schools and Child Care Programs along with Frequently Asked Questions.

Additional Information on vaccine requirements:

- **Hep B**: *Hep B dose #1 is required for babies 0-2 months attending child care. Minimum intervals for valid doses are as follows: The 2nd dose is due at least than 4 weeks after the 1st dose; the 3rd dose is due at least 8 weeks after the 2nd dose and at least 16 weeks after the 1st dose. The final dose of hepatitis B vaccine (HBV) must be at or after 24 weeks of age. If Hep B 3rd dose was given before 24 weeks of age, a 4th dose is needed.

- **DTaP**: The 2nd dose is due 4 weeks after the 1st dose; the 3rd dose is due 4 weeks after the 2nd dose; the 4th dose is due 6 months after the 3rd dose.

- **Hib**: If child is 7-14 months of age, doses are given 2 months apart. If child is at least 15 months old and less than 5 years, a single dose is needed to catch up. A Hib dose at/after 12 months is required for all children under 5 years.
  **If Pedvax Hib is used for the first two doses, only 3 total doses are needed and the 3rd dose of Hib is not due until 12-15 months of age.

- **Poliomyelitis (Polio)**: The 2nd dose is due 4 weeks after the 1st dose; the 3rd dose is due 4 weeks after the 2nd dose. If the child is 4+ years of age, the 3rd Polio may qualify as the child's final dose, but must have a 6 month interval between the last two Polio doses.

  The U.S. currently does not give anything other than IPV (inactivated polio vaccine) whereas some foreign countries still give the OPV (oral polio vaccine). OPV given prior to April 1, 2016 will be presumed to be trivalent and therefore acceptable, regardless of country of administration. Any OPV doses administered after April 1, 2016 are presumed to be bivalent and therefore unacceptable.

- **Hep A: Required for Maricopa County only; Recommended for all other counties.** Children 1 through 5 years of age are required to obtain dose #1 within 15 days of enrollment in child care, preschool or Head Start. Dose #2 is due 6 months after dose #1.

Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120
Phoenix, AZ 85007 • (602) 364-3630

ARIZONA DEPARTMENT OF HEALTH SERVICES

Space for provider office stamp (optional)

Medical Exemption Form

Arizona law requires that schools, preschools and child care facilities retain this form in order for a child to be exempted from immunization requirements for medical reasons.

This is the official ADHS-provided format used by licensed physicians and registered nurse practitioners to document that 1) due to the child's health or medical condition, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccine doses; 2) a child has laboratory evidence of immunity to one or more specific vaccine-preventable diseases and lab results are attached (**required** for measles, rubella, and varicella); or 3) the child has a documented medical history of disease OR laboratory evidence of immunity for diseases other than measles, rubella, and varicella.

Child's Name ____ Date of Birth__________________

To be completed by a licensed physician or registered nurse practitioner to exempt a child from school or child care immunization requirements.

Printed Name of Physician or Nurse ____

Signature of Physician or Nurse _______________________________________Date_______________

Please list each vaccine included in the exemption and the reason for the exemption:

____

____

____

Please indicate whether this is a **permanent** exemption ☐ or a **temporary** exemption ☐

If the exemption is temporary, please list the date the exemption ends ______________________________

Parent/Guardian Section:

1. I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend child care and/or school until the risk period ends, which may be 3 weeks or longer.

2. I am aware that additional information about vaccine preventable diseases, vaccines, and reduced or no cost vaccination services is available from my local county health department and Arizona Department of Health Services. (www.azdhs.gov/phs/immun/).

Parent/Guardian Signature_______________________________________Date_____________________

Arizona Revised Statutes 15-873, http://www.azleg.gov/ArizonaRevisedStatutes.asp?Title=15, and Arizona Administrative Code, R9-5-305, http://apps.azsos.gov/public_services/Title_09/9-05.pdf, and R9-6-706, http://apps.azsos.gov/public_services/Title_09/9-06.pdf describe the requirements for medical exemptions in childcare and school settings.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Arizona law requires that preschools and child care facilities use this official ADHS form to document a religious beliefs exemption to immunization.

Religious Beliefs Exemption Form

For Child Care, Preschool and Head Start Programs

Arizona Department of Health Services (ADHS) strongly supports immunization as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. ADHS also respects the rights of parents who are raising their child in a religion whose teachings are in opposition to immunization to make the decision not to vaccinate their child.

Place an "X" in the box to the left of the disease(s) listed to exempt your child from the vaccine. Initial and date the box on the right.

☐	**Diphtheria (DTaP, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials__________ Date__________
☐	**Tetanus (DTaP, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death.	Initials__________ Date__________
☐	**Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials__________ Date__________
☐	**Polio:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death.	Initials__________ Date__________
☐	**Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and brain damage.	Initials__________ Date__________
☐	**Haemophilus Influenza type b (Hib):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing Hib if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, and death.	Initials__________ Date__________
☐	**Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials__________ Date__________
☐	**Hepatitis A:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death.	Initials__________ Date__________
☐	**Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death.	Initials__________ Date__________

Due to my religious beliefs, I request an exemption for my child from the required vaccine doses selected above. I am aware that if I change my mind in the future, I can rescind this exemption and obtain immunizations for my child.

Initials________________________

- I am aware that additional information about vaccine preventable diseases, vaccines and reduced or no cost vaccination services is available from my local county health department and Arizona Department of Health Services (www.azdhs.gov/phs/immun/).
- I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend child care until the risk period ends, which may be 3 weeks or longer.

Child's Name ____ Date of Birth (month/day/year)________________________

Parent/Guardian Signature____ Date (month/day/year)______________________________

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

BEST OF CARE

This confidential form is to help your child care provider support the growth and development of your child while creating a safe, stable and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH

PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PROVIDER/CENTER NAME

Has your child attended child care in the past? ☐ Yes ☐ No
If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

What did you like most about your child's previous child care setting?

What did you like least?

Other comments:

What is important to you about your child's care?

Who is important to your child?

Does your child prefer to play alone or with other children? ☐ Alone ☐ Other children

Does your child have a favorite toy or comfort object? ☐ Yes ☐ No
If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? ☐ Yes ☐ No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

See reverse for EOE/ADA/LEP/GINA disclosures

CHILD'S NAME

Special things you say or do to comfort your child are?

How do you know when your child is:

Happy?

Sad?

Mad?

Tired?

Other?

How does your child react when:

Something unexpected happens?

Something happens he/she doesn't like?

He/She is scared?

Other?

Does your child have any health issues? ☐ Yes ☐ No

If yes, please explain:

Does your child have any other special needs? ☐ Yes ☐ No

If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? ☐ Yes ☐ No

If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

☐ Parent/Guardian declined to complete

Parent/Guardian Signature Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

ILLNESS FORM

Every year a number of students become ill because of exposure to other ill children. We have listed indicators to help you decide. If your child displays any of these symptoms, it is suggested that you keep your child home.

1. Fever over 100 degrees. A child should be fever-free for 24 hours without medication before returning to school.
2. Green nasal discharge. A child's nose should be completely clear for 24 hours.
3. Persistent cough
4. Diarrhea. A child should be completely free of diarrhea for 24 hours before returning.
5. Nausea or vomiting
6. Pink eye or eye discharge
7. A rash of unexplained origin
8. If your child has been prescribed an antibiotic, they must be on it for 24 hours before returning to school

Please Note:

Children will be sent home at the teacher’s discretion if any of these symptoms are displayed. Our main concern is the best of quality care for your child.

By signing, you are stating you have received and read the Illness Form.

Childs Name_____________________________ Date___________________

Parents Signature____

Release Form for Photographs & Videos

The Springs Preschool + Childcare seeks permission to photograph and/or record videos of you and/or your child(ren) for promotional purposes. These images could appear in promotional material such as but not limited to; newsletters, brochures, bulletin boards, school website and social media accounts.

1. We have permission to use these in our classroom. Yes / No
2. We have permission to use these in our front desk area. Yes / No
3. We have permission to use these in our promotional material. Yes / No
4. We have permission to use these on our school website. Yes / No
5. We have permission to use these on our social media pages. Yes / No

Name of Parent/Guardian_______________________________________

Name of child(ren)____

I hereby grant permission to The Springs Preschool + Childcare to use photographs or videos of me and my child(ren) for promotional purposes and services as indicated above.

Parent Signature________________________________ Date_____________