

**SYLVAN HILLS UNITED METHODIST EARLY LEARNING CENTER
INFANT & TODDLER
PRESCHOOL
REGISTRATION FORM**

Child's Name 1. _____ M/F _____ Birth date _____
2. _____ M/F _____ Birth date _____

Name child prefers to be called: 1. _____ 2. _____

Parent's name _____ Home Phone _____

Address _____ City _____ Zip _____

In case of an emergency (Someone who can be reached if we can't reach you. If you attend O.S.C., please list.)

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____

Father's place of employment (if military, unit or squadron) _____

Mother's place of employment (if military, unit or squadron) _____

Father's Business Phone _____ Mother's Business Phone _____

Mobile or pager number, and/or E-mail address _____

Family Doctor's Name _____ Phone _____

Special Health Conditions or Allergies _____

Any Health Instructions _____

Any Childhood Diseases _____

Has your child attended any school or day care before? _____

How did you learn of our program? Church _____ Sign _____ Friend _____ Other _____

Names of person/persons authorized to pick up my child/children from E.L.C. _____

CONSENT FOR EMERGENCY MEDICAL CARE

I do hereby request and give consent to the Director of the Day Care Facility, or his duly appointed representative, for my child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents/or legal guardians cannot be reached. I hereby give permission for my child to be given transportation to receive emergency medical treatment, by whatever means deemed necessary by the Center Director.

Is there medical or hospitalization insurance which provides benefits for this child? No ___ Yes ___ If so, please indicate:
Name of Insurance Co. _____ Policy No. _____

Date _____ (Signature of Parent or Legal Guardian) _____

Date of Enrollment _____ Date of Discharge _____ Reason: _____

Please check appropriate days and program:

Monday _____ All Three Days _____ Summer Only _____
Wednesday _____ Fall Only _____
Thursday _____ Fall & Summer _____

Discipline Policy

Sylvan Hills United Methodist Early Learning Center uses the following methods of discipline.

Sylvan Hills United Methodist Church Early Learning Center Program does not advocate the use of physical punishment to children of any ages. **

Discipline shall consist of child being withdrawn from current activity and placed in a position apart from his classmates, in the classroom.

The length of time a child is placed in time out shall not exceed one minute, per year, of child's age. (Minimum Licensing Requirements for Child Care Centers: 500.3).

Time out shall not be used for children under two years of age. (Minimum Licensing Requirements for Child Care Centers: 500.10).

Parents shall be given any information on incidents requiring discipline, on their request.

I have read and understand the discipline policy of the day care facility. I give permission for the center to use all methods set out above.

Parent's/Guardian's Signature _____

If the parent/guardian disagrees with any disciplinary method above, please list the method preferred:

_____ Parent/Guardian Signature _____

The center has the right to dismiss any child if their behavior becomes so disruptive that they prevent a positive learning environment for other children or pose a danger to their classmates or teachers. (See Sylvan Hills United Methodist Early Learning Center Information Handbook, Policy # 23.)

**** Please Note: PHYSICAL PUNISHMENT SHALL NOT BE ADMINISTERED TO CHILDREN. (Minimum Licensing Requirements for Child Care Centers: 500.2)**

PARENTAL REQUEST FOR MEDICATION

DATE _____

Child's Name _____

Sylvan Hills Early Learning Center, Director

Sylvan Hills United Methodist Church

has my permission to administer in the event child's temperature exceeds 102° and parents/legal guardians or persons listed on emergency numbers cannot be reached, I hereby authorize the above named child care facility to administer medication.

Drug Name and/or prescription - Tylenol-Liquid/Capsules

Dosage to be given _____

Time to be given _____

Dates to be given _____

Special Instructions _____

Parent/Legal Guardian's Signature _____

Record time medications were given. Initial.

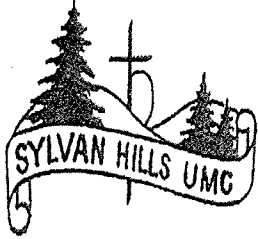
MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY



Sylvan Hills United Methodist Church

Dr. Beverly Watkins
Pastor

Staff:

Judy Fraley

Director: Music Ministries
Coordinator: Programming

Nancy Marlatt

Director: Early Learning
Center & Summer Elementary Programs

Lisa Clarke

Administrative
Assistant

Beverly Neeley

Church Nursery Director

Davis Sims

Director of Youth Ministries

Barbara Walker

Organist

Holly Eaton

Pianist/Adult Bell Director

Arlene Peach

Secretary

9921 Sylvan Hills Hwy. (Hwy. 107)
Sherwood, AR 72120
(501) 835-3410

Visit our Web Site
<http://www.sylvanhillsumc.org>

Arkansas Department of Health & Human Service Immunization Registry

The State of Arkansas has recently created a statewide immunization registry. More than 5,000 Arkansas doctors and clinics submit records of their immunizations to the registry.

The following two forms give permission to the director of our child care facility to access this information. However, to do so, we must have a signed consent form by parents/legal guardians giving us permission to access the immunization record. *The registry is Password protected and only accessible by the director/assistant director of the child care facility.* The only information we will be requesting is strictly the immunization records.

It is your choice to sign the form and therefore we will automatically have immunization records available to us, or you may continue to bring in your "shot records" for updates. In some cases, if immunizations have been received in other states, we may need to see your records to verify the immunizations. The long term goal by the Department of Health is to have an Immunization Registry with nationwide records. Currently, a few of the surrounding states have reciprocal agreements with the State of Arkansas so that their records will be available to each other.

The current form, which is attached, is valid for one year from the date it is signed. It will need to be renewed each year. If, at any time, you wish to discontinue authorization, you may do so by signing the form marked "Revocation Section" and turning the form into the director of the facility.

If you have any questions about the Immunization Registry, please ask Nancy in the Early Learning Center Office.

Sincerely,

Nancy Marlatt, Director
Sylvan Hills United Methodist Church
Early Learning Center

**ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: Sylvan Hills United Methodist Church Early Learning Center
9921 Sylvan Hills Hwy. (Hwy. 107)
Sherwood, AR 72120 (501) 835-3410
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): Immunization Records

Specific information to be disclosed: Immunization Record

"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: One Year from date of signature

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

(Signature of Client)

(Date)

(Witness-If Required)

(Signature of Personal Representative)

(Date)

(Personal Representative Relationship/Authority)

NOTE: This Authorization was revoked on _____

(Date)

(Signature of Staff)

**ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

REVOCAION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

(Signature of Client) (Date) (Signature of Witness) (Date)

(Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

The Department of Health & Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.