



*Mount Sinai  
Christian  
Academy*

*Infant thru Pre-K*

512.451.3185 • fax 512.451.1781  
5900 Cameron Road • Austin, Texas 78723 • e-mail [mschristianacademy@yahoo.com](mailto:mschristianacademy@yahoo.com)

## ENROLLMENT CHECKLIST

1. \_\_\_\_\_ Admission Information
2. \_\_\_\_\_ Birth Certificate
3. \_\_\_\_\_ Immunization Record
4. \_\_\_\_\_ Health Care Professional Statement
5. \_\_\_\_\_ Child Assessment Forms
6. \_\_\_\_\_ Emergency Care Card
7. \_\_\_\_\_ Authorization of Emergency Medical Care
8. \_\_\_\_\_ Child Care Agreement Form
9. \_\_\_\_\_ Talent Release
10. \_\_\_\_\_ Food Program Enrollment Form
11. \_\_\_\_\_ Parent Acknowledgement Form (Parent's Guide to Day Care)
12. \_\_\_\_\_ Class Placement

Kay Fowler  
Director

Start Date: \_\_\_\_\_

# ADMISSION INFORMATION

Operation Name				Director's Name		
Child's Full Name				Child's Date of Birth		
Child's Home Address				Child's Home Telephone No.		
Date of Admission	Date of Withdrawal			Address (if different from child's address)		
Parent's or Guardian's Name						
List telephone numbers below where parents/guardian may be reached while child will be in care:						
Mother's Telephone No.	Father's Telephone No.		Guardian's Telephone No.		Cell Phone No.	
Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:						Relationship
I hereby authorize the childcare operation to allow my child to leave the childcare operation <b>ONLY</b> with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.						

**CHECK ALL THAT APPLY:**

1.  **TRANSPORTATION:** I hereby  give  do not give  consent for my child to be transported and supervised by the operation's employees.  
 Walk home  for emergency care  on field trips  to and from home  to and from school

2.  **FIELD TRIPS:** I hereby  give  do not give  my consent for my child to participate in Field Trips:  
 Parent's Comments:

3.  **WATER ACTIVITIES:** I hereby  give  do not give  my consent for my child to participate in Water Activities:  
 sprinkler play  splashing/wading pools  swimming pools  water table play

4.  **RECEIPT OF WRITTEN OPERATIONAL POLICIES:**  
 I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. **I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:**  
 None  Breakfast  AM Snack  Lunch  PM Snack  Supper  Evening Snack

6. **MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:**

<input type="checkbox"/> Mondays	from: _____ to: _____
<input type="checkbox"/> Tuesdays	from: _____ to: _____
<input type="checkbox"/> Wednesdays	from: _____ to: _____
<input type="checkbox"/> Thursdays	from: _____ to: _____
<input type="checkbox"/> Fridays	from: _____ to: _____
<input type="checkbox"/> Saturdays	from: _____ to: _____
<input type="checkbox"/> Sundays	from: _____ to: _____

**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:**

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name of Emergency Medical Care Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Ph #: \_\_\_\_\_

I give consent for the facility to secure any and all necessary emergency medical care for my child. \_\_\_\_\_  
 Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

Signature – Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

# ADMISSION INFORMATION

**SCHOOL AGE CHILDREN:**  
 My child attends the following school: \_\_\_\_\_ School Ph.# \_\_\_\_\_  
 Name of School and Address \_\_\_\_\_

**CHECK ALL THAT APPLY:**

His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current.  
 Vision and Hearing screening records are also on file.

My child has permission to:  walk to or from school or home,  
 ride a bus, and/or  be released to the care of his/her  
 sibling(s) under 18 years old.

Name of sibling(s): \_\_\_\_\_

**IMMUNIZATION RECORD:**

I have provided the childcare operation with a copy of my child's most current immunization record.

**ADMISSION REQUIREMENT:** If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1.  **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

\_\_\_\_\_ Health Care Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

2.  A signed and dated copy of a health care professional's statement is attached.

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

4.  My child has been examined within the past year by a health care professional and is able to participate in the day care program.

Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional: \_\_\_\_\_

\_\_\_\_\_ Signature - Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____	DATE _____		
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
SIGNATURE _____	DATE _____		<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

Signature – Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

# ADMISSION INFORMATION

## HEALTH REQUIREMENTS

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Vaccine											
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____								

Signature or stamp of a physician or public health  
personnel verifying immunization information above: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the

statement: My child had varicella disease (chickenpox) on or about (date) \_\_\_\_\_ and does not need varicella vaccine.

Parent's signature \_\_\_\_\_

Date \_\_\_\_\_

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official  
notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at  
[www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm)

Signature – Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_



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## HEALTH CARE PROFESSIONAL'S STATEMENT

I have examined \_\_\_\_\_ within the past year  
Child's Name \_\_\_\_\_  
and find that he/she is able to take part in the day care program.

\_\_\_\_\_  
Name of Health Care Professional

\_\_\_\_\_  
Address

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

# AUTHORIZATION OF EMERGENCY MEDICAL CARE

In the event that I cannot be reached to make arrangements for emergency medical care, I authorize the MSCA Director or person in charge to take my child to or see that EMS takes my child to Dell Children's Medical Center at 4900 Mueller Blvd. I give consent for the facility to secure any and all necessary emergency medical care for my child.

\_\_\_\_\_ Child's Name

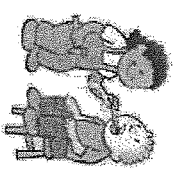
## CHILD'S HEALTH INSURANCE

\_\_\_\_\_ Name of Insurance Plan \_\_\_\_\_ Policy Number

\_\_\_\_\_ Policy Holder's Name \_\_\_\_\_ Expiration Date

\_\_\_\_\_ I do *not* currently have health insurance for my child.

COPY OF INSURANCE CARD



\_\_\_\_\_ Signature—Parent or Legal Guardian \_\_\_\_\_ Date

# Child Assessment Form

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

\* If applicable.

## 1. Health

Does your child have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## 2. Toileting:

Does your child need assistance with toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

## 3. Behavior:

Does your child have any special fears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		
What position is most comfortable for your child when he/she is napping?		

# Child Assessment Form

### 4. Eating Preferences:

What are your child's favorite foods?	
Does your child use utensils, eat with fingers, feed self?	
Does your child choke easily while eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

### 6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	
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I verify that the above assessment was discussed with the parent(s) of \_\_\_\_\_

_____ Signature of Director	_____ Date Signed
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I verify that the director appropriately relayed the information concerning my child's assessment.

_____ Signature of Parent	_____ Date Signed
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Additional Comments:

_____ Additional Comments:
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## MSCA Child Assessment Form

### Spiritual Needs:

What is your child's religious background? \_\_\_\_\_

Does your child attend Sunday School/Church? \_\_\_\_\_

What are the three top values that you would like for your child to keep/have? \_\_\_\_\_

What are your goals for your child while he/she is enrolled at our center? \_\_\_\_\_

### Family Information:

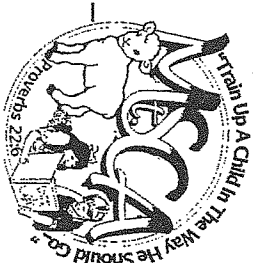
Please tell us anything else that you care to share about your family's race, religion, home language, culture, and family structure.

Please list anything else that you would like to tell us about your child and/or your hopes for our partnership? (You may write on the back.)

Child's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*This information is confidential and will be used only by MSCA staff as a means to become better acquainted with you, your child, and his/her home environment. It will also help us provide the best, most developmentally-appropriate program possible for your child.*



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## Child Care Agreement Form

Please select a payment agreement for the care of \_\_\_\_\_  
(Child's name)

A. I will pay a monthly fee of \_\_\_\_\_. Payment is due in advance. If this fee is not paid by the 3<sup>rd</sup> of every month, I will be charged an additional \$30.00 fee. If the total fee is not paid by that day, the child will be withdrawn from the school.

OR

B. I will pay a Bi-weekly fee of \_\_\_\_\_. Payment is due in advance. If the first half of this fee is not paid by the 3<sup>rd</sup> calendar day of the month, I will be charged an additional \$30.00. The second half of the fee is due the 15<sup>th</sup> calendar day of the month. If the total fee is not paid by the end of the month, my child will be *withdrawn* from the school.

(A fee of \$1.00 per 1 minute will be charged for care after 6:00 p.m. After 6:30 p.m. children will be turned over to the Department of Family and Protective Services.)

*I understand that a 30-day notice is required when I plan to withdraw my child from MSCA. My failure to comply with this procedure will result in the forfeit of any fees paid for the month.*

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Date)



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## Talent Release

Please Print

I have participated in/or will participate in the making of the program listed below:

Program Title: MSCA CHILDREN'S HOUR

Program Producer:

I hereby give permission to the above listed program producer and the Mt. Sinai Christian Academy to use part or all of the program(s) for cablecasting on any media producing airwaves.

Individual Participating: \_\_\_\_\_

Production Date: Every Saturday @ 8:30 a.m.

Production Location: Mt. Sinai MBC Sanctuary

I hereby release all organization and individuals involved in the production of the program(s) as listed above from any privacy, defamation or other claims I may have arising out of the cablecast or promotion of the above listed programs(s).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

## Parent's Acknowledgement

This is to acknowledge that \_\_\_\_\_  
(Name of Facility Staff)  
has provided me with A Parent's Guide to Day Care and has discussed  
its contents with me.

\_\_\_\_\_  
(Signature - Parent)

\_\_\_\_\_  
(Date)

1. Child-care facilities must provide parents with a copy of "A Parent's Guide to Day Care" and review its contents with them.
2. Parents acknowledge receiving the Parent's Guide by signing and dating this form.
3. This acknowledgement is kept in the child's record as long as the child remains at the facility.

Note: Failure to provide parents with A Parent's Guide to Day Care, review its contents, and obtain a signed receipt, is a violation of Standard 2300.A, Day Care Minimum Standards and Guidelines.

## CLASS ASSIGNMENT

Parent recommendation can be given if you would like to have your child remain in their present classroom for the 2009-2010 school year.

The Academy has made the following assignments based on many factors. Several are as follows:

Teacher Recommendation  
Age Appropriateness  
Classroom Openings

Your prayers and patience are needed as this process takes place.

Child's Name:

\_\_\_\_\_

Current/Former Class:

\_\_\_\_\_

Transferred to the

\_\_\_\_\_

New Staff:

\_\_\_\_\_

Teacher conference times: *Please schedule during this transition time. Telephone 451-3185*

## Uniform Policy and Guidance

The school attire is more than just a uniform. It is an example of the unity and school pride in learning for a group of people. Therefore, students ***must*** wear the MSCA uniform Monday through Friday.

The MSCA uniform consists of the following:

- light blue top (short/long sleeve), and
- navy blue bottom (shorts, long pants, skirt, skorts, or jumper).

Uniforms can be purchased at any department store, such as J.C. Penney, Sears, Target, Wal-Mart, Dillard's, etc.,

Kay Fowler  
Director