

**Martha and Mary Children's Services**  
Kindergarten Application

Application Date: \_\_\_\_\_

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

Full-Day Silverdale:

Full-Day Poulsbo:

Jr. Kindergarten Poulsbo:

Child's Name: _____	Nickname: _____	
Sex: _____	Age: _____	Birth date: _____
Address: _____		
City/State/Zip: _____	Phone: _____	
Mailing Address: _____		
City/State/Zip: _____	E-mail: _____ (optional)	

<b>Father</b>	<b>Mother</b>
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Home Phone: _____	Home Phone: _____
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____

Other children in family	Age	School
_____	_____	_____
_____	_____	_____
_____	_____	_____

## EMERGENCY CONTACTS

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

In case of emergency (if parents cannot be reached), please contact the following who have permission to remove my child from the center:

	Name	Address	Phone
1.	_____		
2.	_____		
3.	_____		

In the event my child is injured or becomes seriously ill, and no parent or other responsible person listed can be reached, please contact:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

If the above cannot be reached, Martha and Mary has my permission to arrange for emergency care.

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

Note: Medication will not be given to your child without a Doctor's signature and instructions and written permission of the parent.

Other persons permitted to remove my child from the center:

	Name	Address	Phone
1.	_____		
2.	_____		

Note: We request notification in advance if someone other than the parent will be removing the child.

Visitation rights denied to:

	Name	Address	Phone
1.	_____		
2.	_____		



## PARENT AUTHORIZATION

In considering applications for admission, Martha & Mary Children's Services does not discriminate against any child or family regarding their race, color, creed, religious or economic background.

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

I give permission to Martha and Mary Children's Services to transport my child to and from the site on field trips and other activities. I give the Martha and Mary staff authorization to administer first aid to my child as necessary.

In the event I cannot be reached, I give the Martha and Mary staff permission to obtain medical care for my child. I expect that a conscientious effort will be made to locate my designees or myself. I will accept any expenses incurred.

I give permission for my child to be photographed on field trips and in the classroom, and understand that Martha & Mary Children's Services will attempt to receive my consent for any photos used for publicity purposes.

I understand that if my child will not turn 5 years of age by August 31, 2007, testing may be required by the School District.

I acknowledge that I understand and agree to abide by the policies of Martha and Mary.

Parent Signature: \_\_\_\_\_

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

**Martha & Mary Children's Services**  
**FINANCIAL AGREEMENT**  
**PRIVATE PAY**

1. The undersigned agrees that in consideration of admission to Martha & Mary Children's Services and the rendering of services to the child, the family is obligated to pay all charges incurred in accordance with the payment regulations and current rate schedules of Martha & Mary Children's Services. The rate includes the cost of daily care and all meals for children over the age of one year, except when severe allergies preclude the Center meeting the child's food needs. Certain other charges (including, but not limited to diapers, mats, late payments, ten hour fees and space hold fees) shall be billed on the facility statement. The current rate schedule is attached.

2. Upon application, an advance payment of 50% of one month's tuition is required. This payment is applied to the first month's charges, and is non-refundable if the child does not attend. Payments are due upon receipt of statement each month for monthly services. Credit is not extended unless specifically arranged for in advance and approved by the Director. A late charge is added to accounts not paid in full by the 25th of the month. Accounts not made current by the last day of the month are in default. At that time, the child's enrollment will be terminated until full payment is made. A new initial registration fee will be required before enrollment may continue. Past due accounts bear interest in the amount of 12% per annum. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and all collection expenses. In the event a family voluntarily terminates enrollment, two weeks advance notice must be given.

3. SPACE HOLD. I have been fully informed of and understand the Center's policy on space hold. In the event that the child is removed for one week or more of consecutively scheduled days, the family incurs a daily charge to guarantee the availability of a slot until the Center has been notified otherwise. In the event the space hold fee is not paid, the slot may not be available when the child may require readmission.

The undersigned has read the foregoing and agrees to all of the conditions stated and accepts its terms. A copy will be issued upon request.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Director

\_\_\_\_\_  
Date

Martha & Mary Children's Services  
**CONSENT FOR EMERGENCY TREATMENT**

I hereby give my permission that my child, \_\_\_\_\_ may be given emergency treatment by a qualified staff member of Martha & Mary Children's Services.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child be a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Hospital: \_\_\_\_\_ Medical Insurance: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Chronic Illnesses: \_\_\_\_\_

Regular Medications: \_\_\_\_\_

Date Of Last Tetanus (DPT) Immunization: \_\_\_\_\_

Allergies (Drugs Or Other): \_\_\_\_\_

Other Pertinent Data: \_\_\_\_\_

Child's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Emergency Contacts: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature Of Parent

\_\_\_\_\_  
Date

Martha & Mary Children's Services  
**MEDICATION POLICIES/CONSENT TO ADMINISTER**

*Our policy is: All medications will be given only with prior written consent of the child's parent/legal guardian. Other criteria will be required as defined below.*

**Prescription medications** must be in the original container from the pharmacy and labeled with:

1. child's name (first and last, middle initial if necessary)
2. medication name
3. dosage amount
4. frequency
5. length of time (e.g. days)
6. prescribing physician

**Non-prescription medications** (over-the-counter drugs) such as:

1. antihistamines
2. non-aspirin fever reducers/pain relievers
3. non-narcotic cough suppressants
4. decongestants
5. anti-itching ointments
6. diaper ointments
7. sunscreen
8. vitamins

We will give a child nonprescription medications when:

1. the medication is in its original container, and
2. if the dose and frequency is stated on the label, and
3. the medication is dose appropriate for the age of the child as prescribed on the label of the original container

**All deviations from the label instructions must be accompanied with written consent from a parent and written instructions from a legally authorized health care provider.**

Physician's instructions will include:

1. child's name (first, last and middle initial if necessary)
2. the dose and frequency
3. length of time (e.g. days)

**\*\*NO MEDICATION MAY BE GIVEN IN FOOD OR BOTTLES\*\***

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**CONSENT TO ADMINISTER MEDICATION**

NAME OF CHILD: \_\_\_\_\_

MEDICAL PROBLEM: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

START DATE: \_\_\_\_\_ STOP DATE: \_\_\_\_\_

AMOUNT TO BE GIVEN: \_\_\_\_\_ TIMES OF DAY: \_\_\_\_\_

SPECIFIC INSTRUCTIONS: \_\_\_\_\_

ANTICIPATED SIDE EFFECTS: \_\_\_\_\_

CHILD ALLOWED TO SELF ADMINISTER MEDICINE UNDER STAFF SUPERVISION?: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



Martha & Mary Children's Services  
**ALLERGY INFORMATION FORM**

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

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Symptoms: \_\_\_\_\_

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What to do if symptoms show or allergic reaction is suspected: \_\_\_\_\_

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Other important information: \_\_\_\_\_

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Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Symptoms: \_\_\_\_\_

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What to do if symptoms show or allergic reaction is suspected: \_\_\_\_\_

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Other important information: \_\_\_\_\_

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# Statement of Exemption to Immunization Law

**NOTICE:**

Your Child can be exempted (excused) from immunization for medical, personal or religious reasons. However, if there is an outbreak of a vaccine-preventable disease that your child has not been immunized against, she or he can be excluded from school, preschool or child care until the outbreak is over.

## Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

\_\_\_\_\_ Until \_\_\_\_\_  
Vaccine(s) Date

\_\_\_\_\_  
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

\_\_\_\_\_  
Licensed Health Care Provider Signature Date

## Personal Exemption      Religious Exemption

I am opposed to immunization. I understand that my child can be excluded from attendance during an outbreak.

I do not want my child to receive the following vaccine(s):

\_\_\_\_\_  
Vaccine(s)

\_\_\_\_\_  
Signature of Parent or Guardian Date

## Documentation of Immunity

I certify that the child named on this form has laboratory evidence of immunity to measles/mumps/rubella/varicella.  
(please circle)

Attach TITER results

\_\_\_\_\_  
TYPE or PRINT Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

\_\_\_\_\_  
Licensed Health Care Provider's Signature or Stamp Date

For More Information

<http://www.cdc.gov/nip/recs/child-schedule.htm#Printable>

<http://www.doh.wa.gov/cfh/Immunize/schools.htm>