



FOR OFFICE USE ONLY			
1. \$65 Application Fee Rec'd	Date _____	Ck# _____	
2. \$30 Supply Fee Rec'd	Date _____	Ck# _____	
3. Immunization History Rec'd	Date _____		
4. Birth Certificate Rec'd	Date _____	Early Entrance _____	

25365 State Line Road  
 Lawrenceburg, IN 47025  
 PH: (812) 637-6830 FAX: (812) 637-1892  
 www.godsbrighttreasures.org

**Educare & School Age June 1 2019-August 1 2020**

**NEW STUDENT ENROLLMENT APPLICATION**

Please complete a separate application for each child you wish to enroll. Return the completed form with a check payable to God's Bright Treasures in the amount of **\$95 for each application**, and a copy of the official birth certificate and current immunization records. **The application fee is non-refundable. All payments for tuition after enrolling need to be paid online using Tuition Express.**

**STUDENT INFORMATION** (Please print)

Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Preferred Name to be used in the classroom \_\_\_\_\_ Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Gender:  F  M Birthdate\* \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \*Include a copy of the child's official birth certificate

Age on August 1<sup>st</sup>: years \_\_\_\_ months \_\_\_\_

With whom does the student live?  Both Parents  One Parent  One Parent deceased  Parent & Step-parent  
 Guardian  Other, please explain

Ethnicity (Check One)	
<input type="checkbox"/> 01-Indian/Alaskan Native	<input type="checkbox"/> 04-Hispanic
<input type="checkbox"/> 02-African American	<input type="checkbox"/> 05-White
<input type="checkbox"/> 03-Asian/Pacific Islander	<input type="checkbox"/> 06-Multi-Ethnic

**PARENT / LEGAL GUARDIAN INFORMATION**

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

Street Address: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 (List address if different from above.) (List address if different from above.)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Father's Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

May we call you at work? Yes No Emergency Only May we call you at work? Yes No Emergency Only

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**GUARDIANSHIP:** (Circle One) Guardian's Name \_\_\_\_\_

PARENTS MOTHER FATHER Street Address \_\_\_\_\_

DIVORCED: JOINT GUARDIANSHIP City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

OTHER: \_\_\_\_\_ Day Phone \_\_\_\_\_

RESTRICTIONS: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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## EMERGENCY & TRANSPORTATION INFORMATION

List the name and phone number of the primary person(s) who will be picking this child up from school on a normal basis if other than parents.

1. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship
2. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship

In Case of an **Emergency**, and Parents cannot be contacted, call one of the following (List in order of preference; may be one of the above.)

1. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship
2. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship
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## Consent for Treatment

In the event a child incurs a major injury while at God's Bright Treasures, the local emergency squad will be called. The EMT will decide whether they can administer treatment at the center/ school or whether the child should be transported to the nearest hospital for emergency care.

### Permission to Transport Child:

I give God's Bright Treasures Ministry, Inc. permission to have my child, \_\_\_\_\_  
Name of child

Transported by ambulance to \_\_\_\_\_ Hospital for emergency medical care  
Name of Hospital

and / or to \_\_\_\_\_ for emergency Dental care, or the nearest available source of  
Dentist Name assistance.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Health Record

### Check health conditions that affect your child.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma (Mild / Moderate / Severe) | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Diabetic disorder |
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Tubes in the ear        | <input type="checkbox"/> Heart Condition   |
| <input type="checkbox"/> Bee Sting Allergy                 | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Visual Impairment |

Other: \_\_\_\_\_

**Medical Update:** Please inform us of your child's current health condition, such as allergies, asthma, vision problems, broken bones, physical handicaps, and recent surgeries, hospitalization, injuries or other illnesses.

Allergies: \_\_\_\_\_  
List all allergies and any special precautions and treatment indicated for these allergies: (e.g., food, medication or environmental allergies).

Chronic: \_\_\_\_\_

List any chronic physical problems and any history of hospitalization

Other: \_\_\_\_\_

Does your child require a special diet due to medical reasons? Yes No Explain: \_\_\_\_\_

Does your child require the use of an inhaler or nebulizer treatment on a regular basis? Yes No Explain: \_\_\_\_\_

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**Medications:** Please list your child's current medications and reasons for taking them.

Medication	Dose	Frequency	Reason
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1. \_\_\_\_\_

2. \_\_\_\_\_

Most medications may be taken at home. Any medication, including over the counter medications, to be given during school hours must have a Record of Medication Order (State Form 49968) signed by a physician/nurse practitioner. The form may be obtained in the GBT office or on our website. Parents may have the physician complete the Order in advance of the need, such as in anticipation of headaches, earaches, sore throat, fever, etc... A physician's order is valid for one year. Parents are responsible for providing medication. GBT does not provide any medication for children.

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**Date of most recent dental exam:** \_\_\_\_\_

**Date of most recent physical exam\*:** \_\_\_\_\_

\* Each child must have a physical exam, which includes immunization history, on file with God's Bright Treasures Ministry no later than 30 days after the first day of the child's attendance. The physical exam is valid if conducted within 12 months prior to the first day of attendance. All immunizations must be up to date. Indiana State Child Care Guidelines prevent us from providing service if these requirements are not met. Your child will be excluded from service until the requirement is met. In order to preserve your child's spot in the classroom, normal tuition rates will apply during their exclusion.

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## Development Record

### Language Development & Learning Needs

Was English the **first** language spoken by this child? Yes No If no, what was the first language spoken? \_\_\_\_\_

Which does the child prefer to use? Complete sentences \_\_\_ Phrases\_\_\_ 1 or 2 words\_\_\_ Sounds \_\_\_

Can your child be understood by Parents? \_\_\_ Siblings? \_\_\_ Playmates? \_\_\_ Strangers? \_\_\_

Does your child receive speech therapy? No Yes Where? \_\_\_\_\_

Has your child been diagnosed with ADD/ADHD or other learning difficulty? \_\_\_\_\_

Does your child use hearing aids? No Yes

### Education, Social and Development History

Is this your child's first experience within an educational or childcare setting? Yes No

Has your child attended GBT before? Yes No # years at GBT \_\_\_\_\_

Other childcare centers/schools attended \_\_\_\_\_ # years \_\_\_\_\_

Reason for withdraw from previous provider \_\_\_\_\_

How would you generally characterize your child? Very Outgoing \_\_\_\_\_ Usually Friendly \_\_\_\_\_

Happy \_\_\_\_\_ Solemn \_\_\_\_\_ Shy \_\_\_\_\_ Boisterous \_\_\_\_\_ Other \_\_\_\_\_

Favorite play materials \_\_\_\_\_

Special interests \_\_\_\_\_

Favorite foods \_\_\_\_\_

Does the child have any special fears? Please explain and include any details that may help us fully understand:

\_\_\_\_\_

Was the child born prematurely or in any other unusual circumstance? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Is the child using diapers during the day? \_\_\_\_\_ For nap? \_\_\_\_\_ At night? \_\_\_\_\_

Sleep Habits \_\_\_\_\_

Please see additional questionnaire for Infants.

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**Home and Family**

Members of Household: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Does your family have a home church? Yes No If yes, where? \_\_\_\_\_

Do you or your family members have talents, careers or interests to be shared with our children? \_\_\_\_\_

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**Enrollment 6/1/2019-8/1/2020**

**Desired Start Date:** \_\_\_\_\_ **Is there an anticipated withdraw date?** \_\_\_\_\_

**Attendance -** Please indicate the days you wish your child to attend GBT (three days per week minimum)

**Summer 2019 Attendance**

Monday  Tuesday  Wednesday  Thursday  Friday

Approximate GBT arrival time \_\_\_\_\_ Approximate GBT Pick up time \_\_\_\_\_

**Fall 2019 Attendance**

Monday  Tuesday  Wednesday  Thursday  Friday

Approximate GBT arrival time \_\_\_\_\_ Approximate GBT Pick up time \_\_\_\_\_

**Summer 2020 Attendance**

Monday  Tuesday  Wednesday  Thursday  Friday

Approximate GBT arrival time \_\_\_\_\_ Approximate GBT Pick up time \_\_\_\_\_



**Please select a program based upon your child's age:**

\_\_\_\_\_ **Infants** (6 weeks to 18months old)

\_\_\_\_\_ **Toddlers** (18-36 months old) Is child toilet trained? \_\_\_\_\_ Yes \_\_\_\_\_ Not Yet

\_\_\_\_\_ **Beginners** (Must be age 3 by August 1, 2019 **and independently toilet trained.**)

\_\_\_\_\_ **Pre-K** (Must be age 4 by August 1, 2019 **and independently toilet trained.**)

\_\_\_\_\_ **School Age** \* Please indicate the grade that your child will be entering in the Fall:

- Kindergarten
- First
- Second
- Third
- Fourth
- Fifth
- Sixth

**What school** will your child attend?

- Bright Elementary
- North Dearborn Elementary
- Sunman Dearborn Intermediate

Which daily services meet your needs during the school year?

- Before School
- After School
- Before & After School

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**Parent / Student Handbook Acknowledgement**

I/We, \_\_\_\_\_, the parent(s) / legal guardian(s) of \_\_\_\_\_, acknowledge that I/we have received a digital copy of God's Bright Treasures Ministry, Inc.'s Parent Handbook viewable at godsbrighttreasures.org and have been given the opportunity to read the manual and ask questions about and understand the policies contained therein. Furthermore, I/we agree to abide by the policies set forth in the manual.

I/We understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between GBT and the parents. GBT reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

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

**PARENT'S NOTICE**

State Form 49444 (11-99)/BCD 0035

I understand that this day care ministry is not licensed under the laws of Indiana. However, I understand that this child care ministry must comply with the state rules concerning sanitation and fire and life safety for the primary use of the structure in which it is conducted. I understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the child care ministry.

Signature of Parent or Guardian

Name(s) of children enrolled

This notice does not absolve a day care ministry from liability for injury to a child while the child is at the day care ministry if the cause of the injury is negligence or intentional wrongdoing on the part of the day care ministry or an employee of the day care ministry.

# June 2019 – August 2020 Fee Agreement

## Educare Full Day Program Rates

\$65 Registration fee per child  
 \$30 Annual Supply fee per child  
*These fees are non-refundable*

### Infants 6wks-18mos

- 5 Days \$185/week
- 4 Days \$152/week
- 3 Days \$130/week

### Toddler 18-36mos

- 5 Days \$170/week
- 4 Days \$148/week
- 3 Days \$120/week

### Beginners 3 Years by 8/1/2019 (must be toilet trained)

- 5 Days \$155/week
- 4 Days \$140/week
- 3 Days \$114/week

### Pre-K 4 Years by 8/1/2019 (must be toilet trained)

- 5 Days \$150/week
- 4 Days \$136/week
- 3 Days \$111/week

### *Out of School Services for School Aged*

School Age Before & After School	\$19/day
School Age Before <b>OR</b> After School	\$15/day
School Age Full Day for Closings	\$27/day
<b>Drop-In Care</b> for School Breaks	\$40.50/day

### School Age Full Day – Summer/Breaks

5 Days	\$135/wk
4 Days	\$108/wk
3 Days	\$81 /wk

Person(s) Financially Responsible for the account: Full Name \_\_\_\_\_

Relationship to child \_\_\_\_\_ Phone: \_\_\_\_\_ Employer \_\_\_\_\_

E-Mail Address for financial statements \_\_\_\_\_

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

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