God's Bright Treasures Ministry
Growing in the Light of the Son

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Lawrenceburg, IN 47025
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www.godsbrighttreasures.org

FOR OFFICE USE ONLY

1. $65 Application Fee Rec'd Date _____ Ck# _____
2. Advance Tuition Rec'd Date _____ Amt. _____ Ck# _____
3. $30 Supply Fee Rec'd Date _____ Ck# _____
4. Immunization History Rec'd Date _____
5. Birth Certificate Rec'd Date _____ Early Entrance _____
6. Health Record Rec'd Date _____
7. Medication Order Rec'd Date _____ Start Date _____

Full-Day Educare & School Age June 2018-May 2019

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. **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

Ethnicity (Check One)

___ 01-Indian/Alaskan Native ___ 04-Hispanic
___ 02-African American ___ 05-White
___ 03-Asian/Pacific Islander ___ 06-Multi-Ethnic

Age on August 1st: years ____ months ____

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

PARENT / LEGAL GUARDIAN INFORMATION E-Mail Address for classroom newsletters_____

Mother's Name _____ Father's Name _____

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 _____

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.

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

CHILD'S DOCTOR: _____ DOCTOR'S PHONE: _____

CHILD'S DENTIST: _____ DENTIST'S PHONE: _____

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 _____

Health Record

Check health conditions that affect your child.

☐ Asthma (Mild / Moderate / Severe)	☐ Frequent ear infections	☐ Diabetic disorder
☐ Allergies	☐ Tubes in the ear	☐ Heart Condition
☐ Bee Sting Allergy	☐ Hearing Loss	☐ 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
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 _____

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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

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)

Weekly Attendance

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** (Must be 6weeks to 18months old)

_____ **Toddlers** (Must be 18months old by August 1st 2018 Is child toilet trained? _____ Yes _____Not Yet

_____ **Starters** (Must be age 2 by August 1, 2018 **and able to use the restroom independently.)**

_____ **Beginners (**Must be age 3 by August 1, 2018 **and able to use the restroom independently.)**

_____ **Pre-K (**Must be age 4 by August 1, 2018 **and able to use the restroom independently.)**

_____ 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 2018 – May 2019 Fee Agreement

$65 Registration fee per child

$30 Annual Supply fee per child

These fees are non-refundable

Educare Full Day Program Rates

Infants 6wks-18mos by 8/1/18 **not toilet trained**

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

Toddler 18-36 mos by 8/1/18 **not toilet trained**

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

Starters 2 Years by 8/1/2018 **toilet trained**

- ☐ 5 Days $160/week
- ☐ 4 Days $144/week
- ☐ 3 Days $117/week

Beginners 3 Years by 8/1/2018 **toilet trained**

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

Pre-K 4 Years by 8/1/2018

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

School Age **Full Day – Summer/Breaks**

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

Out of School Services for School Agers

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

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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