The Bridge
CHRISTIAN SCHOOL

4725 K mart Drive, Wichita Falls, Texas 76308
(940) 691-1651
Fax (940) 432-0428

Enrollment Form

Please complete entire form, do not leave blanks. PRINT CLEARLY!

Childs Full Name ____ Date of Birth __________________________
Childs Home Address ____________________________________ City, State, Zip __________________________
Childs Home Phone Number ______________________________ Date of Admission _______________________

Mothers Full Name ___________________________
Mothers Home Phone Number __________________
Mothers Work Phone Number __________________
Mothers Cell Phone Number __________________
Mothers Address ____________________________
Mothers City, State, Zip _______________________
Mothers Email Address ________________________
Place of Employment __________________________

Fathers Full Name _______________________________
Fathers Home Phone Number ______________________
Fathers Work Phone Number ______________________
Fathers Cell Phone Number ______________________
Fathers Address ________________________________
Fathers City, State, Zip ___________________________
Fathers Email Address ____________________________
Place of Employment ______________________________

Is there a custody order on file with The State of Texas? (circle) YES NO PENDING
**If circled YES, a current copy of your court order MUST be attached*

Emergency Contact and Authorization to pick up *Please list 3 local individuals to contact in the event of an emergency*
Name ____________________________ Address _______________________ Phone __________________
Name ____________________________ Address _______________________ Phone __________________
Name ____________________________ Address _______________________ Phone __________________

Permissions *(Please circle)*
I hereby *give / do not give* consent for my child to be transported and supervised by the operations employees for
(Please circle all that apply) Emergency Care Field Trips To and From School
I hereby *give / do not give* consent for my child to participate in field trips
I hereby *give / do not give* consent for my child to participate in water activities
(Please circle all that apply) Sprinkler Play Splashing/Wading Pools Swimming Pool Water Table Play

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.
Parent Signature ____ Date ____________________________

I understand that breakfast, lunch, and afternoon snack will be served.
Parent Signature ____ Date ____________________________

School Age Children My child attends the following school:
Name of School ____
Address, City, Zip, and Phone ____
My child's immunization records, vision, and hearing screenings are on file at the school and are current.
Parent Signature ______________________________________ Date ___________________________________

_____________________________________ _________________________
Parent or Legal Guardian Signature **Date**

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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 ______________________ Emergency Medical Care Facility ________________________

Address_________________________________ Address ____

Phone _________________________________ Phone ____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature of Parent ____ Date ____________________________

Attendance

My child will normally be in attendance the follow days and times:

Day	from:	to:
Monday	7:00 am	5:30 pm
Tuesday	7:00 am	5:30 pm
Wednesday	7:00 am	5:30 pm
Thursday	7:00 am	5:30 pm
Friday	7:00 am	5:30 pm

Special Needs

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during that past 12 months, and medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of: If not applicable, initial here __________________

____

____

____

____

____

Photo Release

From time to time our facility may take photographs for educational use. I give consent for the facility to take photographs of my child.

Parent Signature ____ Date ___________________________________

Outside Employment

I understand that the staff at this facility are prohibited in participating in outside employment with parents.

Parent Signature ____ Date ___________________________________

Social Networking

I understand that the staff at this facility are prohibited in participating in social networking activities with parents and children enrolled at the facility. *(Such as Facebook, MySpace, and Twitter)*

Parent Signature ____ Date _________________________________

_______________________________________ __________________________

Parent or Legal Guardian Signature **Date**

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☐ 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.

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

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

Name and Address of health care professional.

____

____ ____________
Signature-Parent or Legal Guardian Date

Admission Requirement for Children 4 Years or Older

All children 4 years of age or older before September 1 and are not attending pre-kindergarten or school away from the child-care operation are required to have on file annual Vision and Hearing Screening.

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

4. ☐ A signed and dated copy of my child's Hearing and Vision Screenings are attached.

5. ☐ I will have my child's Hearing/Vision Screenings performed and provide a copy within 120 days.

____ ____________
Signature-Parent or Legal Guardian Date

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

My child has had varicella (chickenpox) on or about (date) ____________ and does not need the varicella vaccine.

____ ____________
Signature-Parent or Legal Guardian Date

________________________________ ____________________
Parent or Legal Guardian Signature **Date**

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The Bridge
CHRISTIAN SCHOOL

Tuition Agreement

Child's Name ____ Date of Birth __________________

Mother's Name _________________________________ Father's Name____________________________________

Payment for my child's program is due on Monday of each current week as specified in the current rate schedule. Tuition is payable according to the tuition schedule whether or not my child attends. If tuition and/or late fees are not paid by Wednesday, then I understand that my child cannot return to care until paid. (Parent initials) ____

Weekly Tuition Amount $____________ Non-refundable Registration Fee $____________

In the event of a NSF check or ACH return, a $35 NSF check penalty will be added to my account. If The Bridge Christian School receives 3 or more NSF checks or ACH returns in a one year period of time, your enrollment may be terminated.
(Parent initials) __________

Our program is open Monday through Friday from 7:00 am to 5:30 pm. The Bridge Christian School is only licensed by the Texas Department of Family and Protective Services to care for children during these specified times. If I am late picking up my child, a $1 per minute late penalty will be charged to my account. Late penalties must be paid to The Bridge Christian School before the child can return to care. Regular attendance is imperative to your child's education. If your child will be absent, you agree to notify The Bridge Christian School by 8:30 am each day. Failure to notify The Bridge Christian School may result in a $5 No Call Penalty per day. (Parent initials) __________

During summer months and holiday times, an activity fee may be charged. Activity fees are for additional activities outside our normal planned curriculum. Parents will be notified 30 days in advance of activity fee options. (Parent initials) ________

The Bridge Christian School chooses not to get involved in custody disputes. In the event a court order is on file, The Bridge Christian School will not acknowledge which party is responsible for payment of tuition fees. These arrangements must be coordinated between the two parents. Late fees and withdrawal guidelines will still apply regardless of which parent is responsible for tuition fees. (Parent initials) _______

In the event I choose to end my relationship with The Bridge Christian School and withdraw my child, a two week notice will be given in writing. If I fail to provide a two week notice, I agree to pay for two weeks of care. (Parent initials) _______

School Age Children: The Bridge Christian School has strict policies on before and after school pick up. The safety of my child and the other children being picked up is top priority. Because of this, I agree to notify The Bridge Christian School by 2:00pm each day if my child will not be picked up at their elementary school. If I fail to notify The Bridge Christian School, I agree to pay a $5 no call penalty. On days that the children are not in school, a $12 per day in-service fee will be charged. (Parent initials) _______

Tuition is due whether my child attends or not. (Parent initials) __________

____ ____

Parent Signature Date Director Signature Date

Preparing Little Lives For a Big World

4725 K mart Drive, Wichita Falls, Texas 76308
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CHILD ASSESSMENT

Child's Name ____ Date of Birth ___________________

Mother's Name ____________________________ Father's Name ______________________________

Home Address ____

Please prioritize the best way to be contacted if needed.

___ Home Phone ___________________

___ Mom's Work ___________________ ___ Mom's Cell ___________________

___ Dad's Work ___________________ ___ Dad's Cell ___________________

Emergency Contact Person (This must also be on file with the Director's Office)

Name & Relationship to the student __________________________________ _______________

Contact number ___________________

Are there any languages other than English spoken in the home? Yes / No ___________________________

What is the primary way your child will go home each day? _______________________________________

No you have any specific concerns about your child? (academically, socially, medically, etc.)? _____________

____

Please list any allergies, stings, etc. that may cause allergic reactions with your child ____________________

____

Please list two goals you would like to set for your child this year __________________________________

____

A few of my favorite things: Color __________ Food __________ Movie __________

Book __________ Sport __________ TV Show __________

Animal __________ Song __________ Season __________

Snack __________ Toy __________

One food I really dislike is ____

My favorite thing to learn in school is: ____

The coolest people on earth are: ____

When I grow up I want to be: ____

When I was little I used to: ____

I am awesome at: ____

Three words that describe me: ___________________ ___________________ ___________________

Preparing Little Lives For a Big World

My best friend is ____

If I had one wish it would be ____

Please tell me, in one million words or less, if there is anything else I need to know about your child. Feel free to brag!

____

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NEW [x] **UPDATE** [ ] **DROP IN** [ ]

Institution Name: RED RIVER CCFP Agreement Number: 03114

Facility/Provider Name: The Bridge Christian School 1041

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: ______ Date of Birth: ______ Age: ______

Sex: [ ] Male [ ] Female Date participant enrolled in the facility: ______

Food Allergies: [ ] Yes [ ] No If "yes" specify: ______

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: [ ] Sunday [X] Monday [X] Tuesday [X] Wednesday [X] Thursday [X] Friday [ ] Saturday

Check meals normally eaten at facility: [X] Breakfast [ ] AM Snack [X] Lunch [X] PM Snack [ ] Supper [ ] Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** ______ [X] am [ ] pm **Depart:** ______ [ ] am [X] pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

[ ] White [ ] Black or African American [ ] America Indian/Alaska Native

[ ] Asian [ ] Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers Store Brand - Similac Advanced formula for infants through CACFP. It is your choice
(To be completed by facility/provider)
whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date ______ Birth - 5 months	Today's Date ______ 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date ______ 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: ______ Date: ______

Print Name: ______

Address: ______ City: ______ State: ______ Zip Code: ______

Home Telephone Number: ______ Date Dropped:

Work Telephone Number: ______ Emergency Telephone Number: ______ ______

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA Director Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.

COMPLETE OTHER SIDE

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _______________ ELIGIBILITY NUMBER: _______________

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME: _______________ ELIGIBILITY NUMBER: _______________

Check here if no case number ❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _______________ Print name: _______________

Date: _______________

Address: _______________ Phone Number: _______________

City: _______________ State: _______________ Zip Code: _______________

Last four digits of Social Security Number: * * * - * * - __ __ __ __ ❑ I do not have a Social Security Number