Director/Teacher: Mandy Spohn, *MA*
mspohn@herewegrowlincoln.com
(402) 261-8519
3600 Village Dr. Suite 130
Lincoln, NE 68516

2024-2025 Child Record and Registration Form

Please Fill in ALL of the blanks.

Child's Full Name_____ Gender: M/F Today's date_____
(First, Middle, Last)

Name Your Child Likes To Be Called_____ Birth Date:_____ Age:_____

Primary Home Address:_____ City/State/Zip:_____

Parent/Guardian Email Address: _____

Enrollment Date:_____ Last Enrollment Date: _____

I'm Enrolling My Child For The Following Session:
T/TH 8:30-11:30 AM ($225/mo.) M/W/F 8:30-11:30 AM ($275/mo.) M/T/W/TH 12:30-3:30 PM ($325/mo.)

PARENT/GUARDIAN CONTACT INFORMATION

PARENT/GUARDIAN

Name: _____ Home Phone:_____ Cell:_____

Mailing Address: _____ City/State/Zip_____

Email: _____ Occupation:_____

Employer:_____ Employer's Address:_____

Work Phone:_____

PARENT/GUARDIAN

Name: _____ Home Phone:_____ Cell:_____

Mailing Address: _____ City/State/Zip_____

Email: _____ Occupation:_____

Employer:_____ Employer's Address:_____

Work Phone:_____

Student Lives With: Mother(s)/Father(s)/Both Parents (please circle)

Office Use Only
School Year_____
☐$50.00 Fee ☐Immunization Records

PERSONS PERMITTED TO PICK UP YOUR CHILD FROM SCHOOL (OTHER THAN PARENT/GUARDIAN LISTED)

1. Name: _____ Relationship:_____
2. Name: _____ Relationship:_____
3. Name: _____ Relationship:_____

*Persons listed will need to show a valid driver's license before child will be released to him/her.

EMERGENCY CONTACTS:

Persons listed will take responsibility for the child in an emergency when the parent (or guardian) cannot be reached.

1. Name: _____ Relationship:_____

Home Phone:_____ Cell:_____ Address:_____

2. Name: _____ Relationship:_____

Home Phone:_____ Cell:_____ Address:_____

3. Name: _____ Relationship:_____

Home Phone:_____ Cell:_____ Address:_____

CONSENT TO CONTACT PHYSICIAN IN EMERGENCY

In the event that I cannot be reached to make arrangements, I hereby give my consent to Here We Grow Preschool to contact Doctor_____ Phone_____
Address:_____ City/State/Zip_____ and, if necessary, take my child to the following doctor(s), clinics, or hospital_____
_____

***PARENT/GUARDIAN SIGNATURE _____ Date_____**

MEDICATION COMPETENCY STATEMENT

See the "Here We Grow Handbook" for procedures and policies pertaining to medication.

I,_____(Parent/Guardian Name) have determined _____(Provider/Director) competent to give or apply medication to my child.

***PARENT/GUARDIAN SIGNATURE _____ Date_____**

HELPFUL FAMILY/STUDENT INFORMATION

Siblings and/or Others Who Live In The Home Grade/Age

1._____
2._____
3._____
4._____

Does Your Child Have Any Allergies?: Yes/No
If Yes, Please List:_____
Does Your Child Take Any Medication?: Yes/No
If Yes, Please List:_____

Are There Any Special Concerns You Would Like To Share Regarding Your Child's Health And Wellbeing? _____
_____
_____

Activities Your Child Should NOT Participate In? _____

Company Providing Health and/or Accident Insurance Coverage: (optional)_____

Has Your Child Ever Attended Another Preschool/Daycare?: Yes/No
If Yes, Where and When?:_____

How Did You Hear About Here We Grow Preschool? _____
*If Referred By Someone, Please Include His/Her Name.

*While it is preferred, it is not mandatory that your child be toilet trained before enrolling at Here We Grow.

Does Your Child Carry Out The Bathrooming Routine?: Yes/No Independently/With Help

How Does Your Child Indicate That He/She Needs To Use The Bathroom?
_____

What Are Some Daily Routines That You And Your Child Enjoy Doing Together?
_____
_____

What Does Your Child Love? _____
Is There Anything That Scares Your Child?_____

What Else Would You Like To Share About Your Child? (communication, pictures, successful or challenging routines, discipline, hopes you have for your son or daughter, special family traditions, etc…)

Consents (please initial each)

____ Yes, my child may be photographed for classroom purposes (creating books, bulletin boards, class newsletters, slideshows, artwork, etc…).
____ Yes, my child may be videotaped for classroom purposes (class dvd's and slideshows).
____ Yes, my child may be photographed/videotaped for additional purposes (website, Facebook page, neighborhood publications).
____ Yes, my child may take walks in the neighborhood with the class accompanied by supervised adults.
____ I understand that as long as my child is enrolled at Here We Grow Preschool, during the school year or Summer Camp Program, I am responsible to pay tuition (as outlined in the Here We Grow Handbook) each month. Tuition rates will be the same regardless of inclement weather closings, early withdrawal, absences, vacations, and holidays.

PARENT/GUARDIAN SIGNATURE _____ **Date**_____

Transportation Permission

I hereby give Here We Grow Preschool permission to transport or arrange for transportation for special events for my child, _____(Child's Name). I understand that preschool staff will ensure that my child is secured in a safety restraint at all times the vehicle is in motion.

PARENT/GUARDIAN SIGNATURE _____ **Date**_____

Certificate of Immunizations

Please complete **OR** attach a copy of your child's most recent immunization records.

First Name:	**Last Name:**	**Date of Birth:**

PCV 1 / /	DTaP 1 / /	IPV 1 / /	HIB 1 / /	HEP-B 1 / /	MMR 1 / /	VAR 1 / /
PCV 2 / /	DTaP 2 / /	IPV 2 / /	HIB 2 / /	HEP-B 2 / /	MMR 2 / /	VAR 2 / /
PCV 3 / /	DTaP 3 / /	IPV 3 / /	HIB 3 / /	HEP-B 3 / /		
PCV 4 / /	DTaP 4 / /	IPV 4 / /	HIB 4 / /	***REFUSAL:	( ) Copy of Immunization Refusal Form must be included with this report.	
	DTaP 5 / /			***VARICELLA:	( ) Copy of Varicella Disease Verification Form must be included with this report.	

PCV – Includes PCV7 or 13, (Prevnar) and PPV23
DTaP – Includes DtaP and DTP (Diptheria, Tetanus, Pertussis)
DT (Diphtheria, Tetanus – Pediatric)
Td (Tetanus, Diptheria – Adult)
IPV – Includes OPV (Oral Polio Vaccine)
IPV (injectable Polio Vaccine

HIB – Haemophilus Influenzae Type B
Hep B – Hepatitis B
MMR – Measles, Mumps, Rubella
VAR – Varicella VZV

***Refusal**: If for any reason you have refused any or all of the above immunizations, please request a refusal form from your childcare director.
*** **Varicella:** Please request the Copy of Varicella Disease Verification Form form ONLY if your child HAD the Chickenpox Disease.

I certify that the above/attached information is correct to the best of my knowledge.

GUARDIAN SIGNATURE _____ **Date**_____