

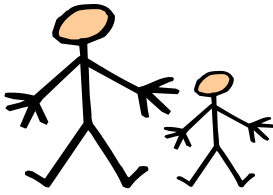
# Trinity Tots

A Mother's Day Out Ministry of Trinity Assembly

## **APPLICATION PACKET 1.1**

Please complete one packet per child.





# Trinity Tots

A Mother's Day Out Ministry of Trinity Assembly

Parents & Guardians:

Welcome to Trinity Tots, a Mother's Day Out ministry of Trinity Assembly. We are so excited about the opportunity to minister to your child. Please take note of the following important information:

- Our day begins at 8:30 am. Please do not arrive before this time; the teachers need this time to prepare their rooms for the day. Children need to be picked up promptly at 2:30 pm. **A late fee of \$1 per minute is charged after 2:35 pm and is due the same day.** We will use the clock in the sign in area as our "official" time.
- Payment is due on the first school day of each month for the entire month. Your child will not be permitted to return until payment is made.
- We follow the Putnam County School schedule so please watch Channel 7 for snow days or school cancellations. You will not be required to pay for days that we cancel the program.
- In order to hold your child's place in his class, you must pay even if sick or absent.
- Please be sure to send lunches that are ready to eat (include utensils, peel and cut food if necessary, put foods in a thermos if your child wants it warm).
- **LABEL EVERYTHING** you send to ensure getting it back in the right hands.
- Please read the Preschool handbook.

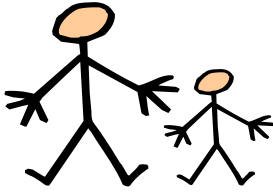
Please sign and return this form to the Trinity Tots Director.

I have read and understand the above policies.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_





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## TUITION AND ENROLLMENT AGREEMENT

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

Class: \_\_\_\_\_

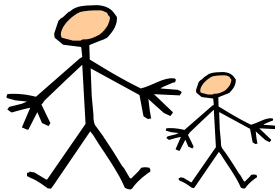
Parent's Name: \_\_\_\_\_

- I agree to the printed policies of the Mother's Day Out program of Trinity Assembly and will cooperate with teachers for the development of my child. I will regularly pay the tuition as stipulated in the program policies.
- I agree to notify the program's director with a **2 week notice** before withdrawing my child from the program for any purpose.
- I understand the program and the church will take every reasonable precaution to prevent accidents. I will not hold the program, church or the teachers liable for unavoidable accidents.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_





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## INDIVIDUAL CHARACTERISTIC FORM

### I. Identifying Information

Enrollment Days (please circle one)    Tuesdays    Thursdays    Both

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

Birthdate \_\_\_\_\_    Age \_\_\_\_\_    Sex \_\_\_\_\_

Address \_\_\_\_\_  
(street)

\_\_\_\_\_ (city)    \_\_\_\_\_ (state)    \_\_\_\_\_ (zip)

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

Contact Phone \_\_\_\_\_ (Day)    \_\_\_\_\_ (Evening)

Occupation \_\_\_\_\_

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

Contact Phone \_\_\_\_\_ (Day)    \_\_\_\_\_ (Evening)

Occupation \_\_\_\_\_

Brother's & Sister's Names    Ages

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Religious Affiliation \_\_\_\_\_

Home Church \_\_\_\_\_

**II. Personal Health**

1. Describe general physical make up of child.

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2. List any known allergies which the child may have.

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3. List special needs that may help your child's teacher relate to him.

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**III. Living Habits & Emotional Development**

1. Give all the information you can on the following:

Toilet habits \_\_\_\_\_

Eating habits and difficulties \_\_\_\_\_

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Sleep habits \_\_\_\_\_

Bedtime \_\_\_\_\_

Daytime nap \_\_\_\_\_

Does your child resist bedtime or nap time? \_\_\_\_\_

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Behavior habits (biting nails, sucking fingers, tantrums, biting, stammering, etc.) \_\_\_\_\_

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2. Can your child care for himself completely?

Dressing                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

Brushing Teeth        \_\_\_\_\_ Yes                    \_\_\_\_\_ No

Toileting                \_\_\_\_\_ Yes                    \_\_\_\_\_ No

Tying Shoes             \_\_\_\_\_ Yes                    \_\_\_\_\_ No

3. Does your child have any fears (please state them)? \_\_\_\_\_

4. Do you know the causes of these fears? \_\_\_\_\_

5. What are your child's reactions to strangers? \_\_\_\_\_

6. Does your child cry easily? \_\_\_\_\_

Please state the main causes \_\_\_\_\_

7. What types of controls or discipline are used in the home?

8. Is it easy for your child to be separated from either parent?

#### **IV. Play Life**

1. Does your child have his own room? \_\_\_\_\_

A place to put his toys away? \_\_\_\_\_

2. Does the child play well with others? \_\_\_\_\_

3. Is it difficult for your child to share? \_\_\_\_\_

4. Can your child amuse himself? \_\_\_\_\_

5. Please list special interests and preferred toys.

**V. Health Information**

Program: Trinity Tots

Address: 205 W. Wall Street, Algood, TN 38506

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

Date of Birth \_\_\_\_\_

**Medical History**

Chicken Pox                      Yes                      No                      Date \_\_\_\_\_

Convulsions                      Yes                      No                      Date \_\_\_\_\_

Flu                                      Yes                      No                      Date \_\_\_\_\_

Measles                              Yes                      No                      Date \_\_\_\_\_

Meningitis                      Yes                      No                      Date \_\_\_\_\_

Mumps                              Yes                      No                      Date \_\_\_\_\_

Whooping Cough              Yes                      No                      Date \_\_\_\_\_

Allergies (please list)

\_\_\_\_\_

\_\_\_\_\_

Is there any evidence of:

Hearing loss or difficulties? Yes                      No

Vision difficulties?                      Yes                      No

Speech disabilities?                      Yes                      No

List any:

Hospitalizations \_\_\_\_\_

Operations \_\_\_\_\_

Other serious illnesses \_\_\_\_\_

**Immunizations** (please give dates)

OPT or Diphtheria \_\_\_\_\_

Whooping Cough \_\_\_\_\_

Tetanus \_\_\_\_\_

Poliomyelitis \_\_\_\_\_

Measles (Rubella) \_\_\_\_\_

All immunizations are up-to-date                      Yes                      No

If no, indicate reason \_\_\_\_\_

Results of tuberculin skin test or chest x-ray \_\_\_\_\_

Is the child free from communicable disease?    Yes                      No

List any medications and drugs taken regularly by the child.

\_\_\_\_\_  
\_\_\_\_\_

Other remarks regarding physical condition \_\_\_\_\_

\_\_\_\_\_  
The above information is correct as of the following date: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Phone \_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR CHILD'S SHOT RECORD**

**VI. Photo Release**

I, \_\_\_\_\_, give Trinity Assembly of God, Inc. the permission to record the image and / or voice of the minor named below, and I grant Trinity Assembly of God, Inc. all rights to use the sound, still, or moving images in any medium for educational, promotional, advertising or other purposes that support the mission of the Trinity Tots program. I agree that all rights to the sound, still, or moving images belong to Trinity Assembly of God, Inc.

Parent / Guardian Name \_\_\_\_\_  
(please print)

Minor's Name \_\_\_\_\_

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

Date \_\_\_\_\_

