ST. JOHN'S EARLY LEARNING CENTER
2022-2023
Registration Form

Date: _____ Child's Name: _____ Class: _____

Date of Birth: _____ Gender: _____ Start Date: _____

Billing Information for Financially Responsible Parent:

Last Name: _____ First Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

ANNUAL TUITION WILL BE INVOICED IN EQUAL 12 MONTH INSTALLMENTS AS FOLLOWS:
~Please circle one option~

	Toddler 1	Toddler 2	Preschool/Pre-K
2 Day Option (T/Th)	**$825**	**$805**	**$670**
3 Day Option (M/W/F)	**$1,240**	**$1,200**	**$1,010**
5 Day Option (M-F)	**$1,625**	**$1,605**	**$1,340**

REGISTRATION FEE – Non-refundable: $175 Registration + $35 Smart Tuition fee. At the time of registration, you will be given a web link to create a Smart Tuition account and pay your Registration and Smart Tuition fee. Your registration will not be complete until this is done.

ENROLLMENT - Within a few days of registering, you will receive an email from TADS asking you to complete our online enrollment process. Your registration will not be complete until this is done.

I hereby give permission to St. John's ELC to call a doctor or 911 for my child, should an emergency arise. It is understood that every effort will be made to locate family/guardians/persons listed as emergency contacts before any action will be taken. The people listed as emergency contacts are also authorized to give consent for emergency care regarding my child, unless otherwise specified. I give St. John's permission to share medical information regarding my child with teachers and support staff who are responsible for my child's safety and well-being during the school day.

Parent or legal guardian signature: _____ Date**: _____**

GENERAL HEALTH APPRAISAL FORM

PARENT

Please complete, date, and SIGN.

Child's Name: _____ Birthdate: _____

Allergies: ☐ None OR ☐ List food/medication: _____

Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-Describe: _____

Skin Care: ☐ Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

Sleep: Your healthcare provider recommends that all infants less than 1 year of age be placed on their back for sleep.

I, _____, give permission for my child's healthcare provider to share this form and applicable attachments with my child's school, childcare, or camp. Contact information for the person to receive this form:
Name:_____ Fax:_____ Email:_____ _____

Parent/Guardian Signature:_____Date:_____

HEALTH CARE PROVIDER

Please complete after parent section has been completed.

Date of most recent health appraisal: _____ Age:_____ Weight: _____

Physical Exam: ☐ Normal ☐ Abnormal-describe: _____

Allergies: ☐ None OR ☐ List food/medication: _____ Type of Reaction _____

Current Medications: ☐ None OR ☐ List:_____

A separate medication authorization form (**link**) is required for medications given in school, childcare, or camp.

Current Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-describe: _____

A separate diet statement (**link**) is required for food provided at school, childcare, or camp.

Health Concerns: ☐ Severe Allergies ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Behavior Concerns
☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Oral Health ☐ Under/Overweight ☐ Other: _____

Explain above concerns (if necessary, include instructions to care providers): _____

Immunizations: ☐ See attached immunization record or official exemption form ☐ Next vaccine due date: _____

HEALTH CARE PROVIDER

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.

Height: _____ B/P: _____ Head Circumference (up to 12 months): _____ HCT/HGB:_____

Lead Level: ☐ Not at risk OR ☐ Lead level: _____ TB: ☐ Not at risk OR Test Result: ☐ Normal ☐ Abnormal

Screens Performed: ☐ Vision: ☐ Normal ☐ Abnormal ☐ Hearing: ☐ Normal ☐ Abnormal
☐ Oral Health: ☐ Normal ☐ Abnormal Developmental Screen: ☐ ASQ ☐ PEDS ☐ Other: _____

Developmental Concerns: _____ Recommended Follow-up: _____

PROVIDER SIGNATURE

Next Well Visit: ☐ Per AAP Guidelines* or ☐ Age: _____

This child is healthy and may participate in all routine activities in school, childcare, or camp. Any concerns or exceptions are identified on this form.

_____
Signature of Healthcare Provider (certifying form reviewed)

_____
Date

*The AAP recommends Well Child Visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, and annually after 3 years.

OFFICE STAMP

Or write Name, Address, Phone Number, Email

The form was created by the American Academy of Pediatrics, Colorado Chapter and Healthy Child Care Colorado to satisfy childcare and Head Start requirements in Colorado. While accepted by most schools, childcare programs and camps, this is not an official government form. Updated 01/2021.