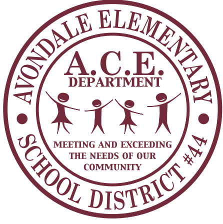
Avondale Elementary School District



A.C.E. Preschool
Copper Trails & Wildflower

2015-2016
Registration and Enrollment Check List

Complete Registration and Enrollment packet in its entirety. One packet is required for each child. Check off each item as you complete it to be sure all of the registration and enrollment requirements are met. Incomplete forms will NOT be accepted. Once complete, you are ready to proceed:

_____ Fill out the Registration form in its entirety: all questions must be answered

_____ Fill out Emergency, Information and Immunization Record Card form in its entirety

_____Fill out Emergency Information School Nurse Form in its entirety

_____ Attach **photocopy** of child's birth certificate

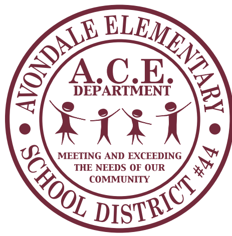
_____ Attach **photocopy** of child's current immunization records

_____ Attach payment
Payment by personal check, cashier's check or money order
Made Payable to: Avondale Elementary School District

_____ Completed registration packet and registration fee can be submitted to:
(The first payment may also be required depending on when a registration is submitted.)

1. Wildflower School or Copper Trail School Front Office
2. A.C.E. Preschool Teacher
3. Mail or drop off to District Office:
   Avondale Elementary School District
   A.C.E. Department
   295 West Western Avenue, Avondale 85323

IMPORTANT: Registration forms with missing information or documentation will NOT be accepted.



A.C.E. Preschool
2015-2016 Enrollment

To be completed by employee accepting this registration	
Date received:	
Payment amount:	
Reviewed by:	
Start date:	

Please complete all sections. Forms with missing information will not be accepted. Annual registration is required.

Program Site

☐ Copper Trails School:
AM Preschool ❖ PM Preschool
Preschool (age 3 - school aged)

☐ Wildflower School:
Full Day ❖ AM Preschool
PM Preschool ❖ Extended Care
Preschool (age 3 - school aged)

Please mark one program session

☐ AM Only
Preschool Instruction 8:00am-11:15am

☐ PM Only
Preschool Instruction 12:15pm-3:30pm

☐ Full Day- Wildflower School Only
Breakfast, Lunch and Snacks Included- 6:15am -6:00pm

Please mark optional additional care programs you are enrolling in: (additional fees apply)

☐ AM Extended Care 6:15am-8:00am
(Available only at Wildflower Campus)

☐ Extended Mid-day 11:15am-12:15pm / Lunch Provided
(Available only at Wildflower Campus)

Child's Full Name: ______________________ Birth Date: ____________ Age: ______

Address: ______________________________ City & ZIP ______________

Payer Name: ______________________ Relation (if not parent/guardian) ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: (If different) ______________________________ City & ZIP ____________

The following information will be useful when doing projects. All of the information is confidential and the use is intended for classroom purpose only. Thank you.

Siblings 1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

Natural Mother Living? ☐Yes ☐No Natural Father Living? ☐Yes ☐No Parent are ☐Married ☐ Divorced

Child Lives With? ☐Both Parents ☐Mother ☐Father Other (specify) ______________

ETHNICITY: (check one) ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

RACE: (Please check all that apply and circle the primary race) ☐ White ☐Black / African American ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander

Does this student currently have an IEP (Individual Education Plan)? ☐Yes ☐No
Does this student currently have a 504 Accommodation Plan? ☐Yes ☐No
Does this student have any physical or mental impairment? ☐Yes ☐No

Please read and initial each of the following:

_____ I understand that this student must be fully toilet trained to attend this program pursuant to AZ Department of Health Services licensing regulations.
_____ I grant permission for my child to participate in internet activities. Students are expected to follow District internet usage rules and regulations.
_____ I grant permission for my child's photograph to be taken for publicity purposes at the discretion of the AESD Administration.
_____ I grant permission for my child's photograph, interview, video and/or audiotape to be posted on the official AESD Facebook page.

Mother/Guardian Name: ______________________ AESD Employee: ☐Yes ☐No

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ______________________________ City & ZIP ____________

Email address: ______________________________

Father/Guardian Name: ______________________ AESD Employee: ☐Yes ☐No

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Address: ______________________________ City & ZIP ____________

Email address: ______________________________

2015-2016 Preschool

Non-Refundable Registration Fee (Per Family)	$30 fee (50% off before June 3, 2015)
AM Only Preschool Instruction 8:00am-11:15am	Monthly Rate $225*
PM Only Preschool Instruction 12:15am-3:30am	Monthly Rate $225*
AM Extended Care- Available only at Wildflower Campus (6:15am-8:00am)	Monthly Rate $100
Extended Mid-day - Available only at Wildflower Campus- Lunch Provided (11:15am-12:15pm lunch meal included)	Monthly Rate $100
Full Day-Wildflower Campus ONLY Breakfast, Lunch and Snacks Included 6:15am -6:00pm	Monthly Rate $600*

*Tuition rates are based on annual fee of $2,250 for half day or $6,000 for full day, payable in ten equal installments. Short months are not pro-rated, and missed days are not credited.

Discount Fee Information

Please check below if you are eligible for a discount: only one discount will be applied and qualifying information must be provided.

☐	10% multiple child discount on second child in program	(name of other child)	
☐	20% AESD employee discount (only one discount may be applied)	(position and location)	
☐	10% military discount (only one discount may be applied)	(military badge required)	

Additional Fee Information

	$25 fee for each change made to enrollment after registration
	$15 late payment fee

Please choose a payment plan option for the balance of your tuition.

One full month's tuition plus the registration fee is due at the time of registration and both of these fees are non-refundable.

1. ☐ I will submit monthly payments to the A.C.E. Department by the first school day of every month, September through May, using payment coupon book
2. ☐ Pay in full at time of enrollment

I agree to read the Preschool Parent Handbook and to follow all policies and procedures covered in the handbook. I understand there are conditions that may result in withdrawal of my child from the Preschool program, and that all AESD rules, policies and procedures apply to this program. Tuition for this program is based on an annual fee with the option to pay on a monthly basis. One full month's tuition plus the registration fee is payable with this registration and is non-refundable.

Parent /Guardian Printed Name:______________________________ Date: ____________________

Parent/Guardian Signature______________________________ Date:____________________

Avondale Elementary School District #44
EMERGENCY INFORMATION FOR SCHOOL NURSE and CONSENT FOR RELEASE OF MEDICAL INFORMATION

☐ **MAS** ☐ **ECF** ☐ **LCE/W** ☐ **WF** ☐ **DS** ☐ **DT** ☐ **CM** ☐ **CT**

The care your child receives is dependent on this information being on file in the Nurse's Office. **Please submit a new form each school year.**

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STUDENT'S NAME **DATE OF BIRTH** **GRADE** **TEACHER**

Name	*Address*	*City*	*Home Phone*	*Cell Phone*
Father:				
Mother:				
Guardian:				

Employer	*Address*	*City*	*Business Phone*	*Occupation/Work Place*
Father:				
Mother:				
Guardian:				

Child lives with: ☐Both parents ☐Mother ☐Father ☐Other (specify)________________________

Brothers and sisters living at home:

Name	*Age*	*School*	*Name*	*Age*	*School*

In your absence, name two relatives or friends who will be responsible for your child if she/he is hurt or becomes ill while at school:

Name	*Address*	*City*	*Home/Cell Phone*	*Relationship*
1.				
2.				

Doctor your child visits (in an extreme emergency, 911 will be called):

Healthcare Provider's Name	*Address*	*Phone Number*

Is your child currently receiving Behavioral Health Services? Yes____ or No____

Counselor/Psychologist/Behavioral Health Services Name	*Address*	*Phone*

Medical Insurance: ________________________ ID.#: __________________________ Hospital: ________________________

Medical History: Check those that apply to your child:
__Asthma __Food Allergies __Diabetes __Seizures __ADD/HD __Eye, Ear or Nose Problem __Urinary/Bowel Problem
__Serious Injury/Accident __ Speech Difficulty __Heart Problem __Cancer

Other (i.e. frequent illnesses, hemophilia, headaches):____

If any of the above is checked, PLEASE NOTIFY SCHOOL NURSE, explain and give date(s):________________________________

Please list present medications: _______________________________________Are medications needed at school? Yes____No___
If yes, please request Medication Consent Form from School Nurse

Allergic to: ____Wears glasses/contacts: __Full time __Reading __Distance

Changes during the summer (For example: Divorce, Separation, Death, Other): ____________________________________

Is there anything you can tell us about your child that you feel will help the school staff to better understand and work with him/her?____

Please check the medications that your child may receive at school:

__Cough Drops/Lozenges __Tylenol __Ibuprofen/Motrin/Advil __Benadryl Elixir/Capsules __Tums/Antacids

Any other medication that you want your child to take at school must be provided by you in the original container or prescription bottle, and you must sign a separate medication permission form that can be obtained from the Nurse.

I give my consent/permission to obtain/release medical information regarding my child to/from any physician/hospital if required.

Signature of Parent or Guardian: ____ Date: ____________________

CDC/SGH# or name:____________________

Arizona Department of Health Services

Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Mother or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Father or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of injury or sudden illness, I request that this individual be called first:

Does your child have insurance coverage? ☐ No ☐ Yes Name of Insurance Company:

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):________________

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

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Medical Information

Is child allergic to food or other substances? ☐ **No** ☐ **Yes** **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** **If yes**, specify procedure:
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ **No** ☐ **Yes** **If yes**, list precautions:
Additional comments:
Other special instructions:

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**