



WELCOME TO REGISTRATION

Please complete the following checklist items to enroll your child at Cactus Wren and/or to volunteer in your child's class.

ALL forms must be fully completed and returned at fall orientation, or three business days before your child's first day of class, if starting during the school year. Information on these forms is required by the Arizona Department of Health Services, Office of Childcare Licensure.

Student Name:

Date:

REGISTRATION CHECKLIST	
STUDENT REGISTRATION FORMS- REQUIRED FOR ALL STUDENTS	
_____	Application Form
_____	Emergency Information & Immunization Form: Please fill in all spaces completely, including full addresses and telephone numbers. You must have at least 2 people listed as Emergency contacts.
_____	Copy of your child's immunization record, or Religious Beliefs Exemption Form.
_____	By-laws Agreement and Hand Sanitizer Permission Form
_____	Adult Participation Contract
_____	Application Fee: \$50.00 for the first child, \$40 for second child. Due at time of enrollment.
_____	Tuition- First and last month's due at fall orientation, or three business days before the first day of class if enrolling after the school year starts.
PARENT CLASSROOM VOLUNTEER FORMS	
_____	TB Verification Form: Can be completed at the Cochise County Health Department or by your personal Physician. The Health Department is located at 4115 E. Foothills Drive. Their telephone number is (520) 803-3900. TB tests are only given on Tuesdays by appointment only. A fee will apply.
_____	Fingerprint Clearance Card: Please visit the AZ Department of Safety website at https://www.azdps.gov for information.



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: <input type="checkbox"/> male <input type="checkbox"/> female

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

Parent 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:
(Pursuant to R9-5-304.B, at least two contact persons are required.)**

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

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

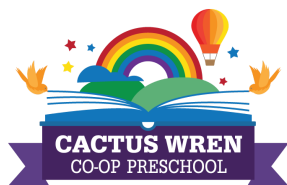
Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	No	Yes
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	No	Yes
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	No	Yes
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.)? If yes, list precautions:	No	Yes
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:
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Parent Orientation & By-laws Agreement

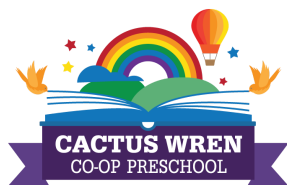
I/We, _____ have read, understand, and agree with the policies in the 2020-2021 Orientation Manual. I also have read and understand the Cactus Wren By-laws.

Signature

Date

Signature

Date



Hand Sanitizer Permission Form

I give permission for Cactus Wren Cooperative preschool program to allow my child _____ to use hand sanitizer periodically throughout the school year in addition to soap and warm water to clean his/her hands while at school. Hand Sanitizer will only be used in some instances when hands are visibly soiled.

Signature

Date

Signature

Date



Adult Participation Contract & Photographic Release Form

1. I agree to be bound by the rules and policies of Cactus Wren Cooperative Preschool
2. I understand the required duties of the adult members of the Cactus Wren Cooperative Preschool to include
 - a. Mandatory attendance at the Spring General Membership Meeting to receive a \$10.00 tuition rebate.
 - b. Being responsible for my committee assignments after receiving a written job description (if applicable).
 - c. Working the equivalent of six hours per year in maintenance, cleaning, upkeep, building projects, fundraising events, committee duties or board membership. This requirement is in addition to any classroom volunteer workdays.
 - d. Reading the Orientation Manual.
3. I agree to pay my monthly tuition in full by the first of each month. I understand that it is my responsibility to notify the Financial Director of any special circumstances, and an additional \$20 will be assessed for late payment received after the seventh of each month. I understand that prepayments may only be made in full monthly increments.
4. I understand that if tuition is not received by the fifteenth of each month, the matter will be turned over to the Executive Board for a decision regarding removal of my child from the preschool.
5. I will agree to abide by all the health standards of the preschool.
6. If I choose to volunteer in my child's classroom, I will first provide verification of a TB skin test or a chest x-ray dated less than one year prior to the child's entry into Cactus Wren Cooperative Preschool. I will be fingerprinted and will apply for an Arizona DPS Fingerprint Clearance Card, and provide Cactus Wren Cooperative Preschool with verification of fingerprinting and a copy of my DPS Fingerprint Card when I receive it. I will also provide a current shot record for myself or an Immunization Verification testifying to the best of my knowledge that my immunizations against Measles, mumps, diphtheria, rubella and pertussis are current.
7. When I volunteer in the classroom, I agree to arrive 15-30 minutes before class starts to help the teacher set up, and to stay up to 30 minutes after class to help clean up. I agree to complete all tasks assigned to me on the Classroom Volunteer Checklist.
8. Withdrawal from Cactus Wren:
 - a. Before withdrawing my child from Cactus Wren Cooperative Preschool, I will give at least two week's notice to the Assistant to the Director.
 - b. I understand that during the said notice period, tuition is in fact due and payable.
 - c. I understand that during the said notice period, the Financial Director will notify me of the status of my account.
 - d. I agree that monies paid, to include May's tuition are NOT refundable except under the conditions listed in the Orientation Manual. All tuition owed is to be paid.
9. I will complete a teacher evaluation form during the year.
10. **Release for photographs (Please select the appropriate box below and initial your selection):**

YES, I GIVE my permission for photographs of myself, my child, and my family members present at Cactus Wren Cooperative Preschool, events or outings to be used on the school website, on the school Facebook page, on Cactus Wren brochures or publicity materials and in publications (such as the Sierra Vista Herald). **Please initial here** _____.

NO, I DO NOT give my permission for photographs of myself, my child, and my family members present at Cactus Wren Cooperative Preschool, events or outings to be used on the school website, on the school Facebook page, on Cactus Wren brochures or publicity materials and in publications (such as the Sierra Vista Herald). **Please initial here** _____.

Signature: _____

Date: _____



Religious Beliefs Exemption Form

For Child Care, Preschool and Head Start Programs

Arizona Department of Health Services (ADHS) strongly supports immunization as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. ADHS also respects the rights of parents who are raising their child in a religion whose teachings are in opposition to immunization to make the decision not to vaccinate their child.

Place an "X" in the box to the left of the disease(s) listed to exempt your child from the vaccine. Initial and date the box on the right.

<input type="checkbox"/>	Diphtheria (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials _____ Date _____
<input type="checkbox"/>	Tetanus (DTaP, Tdap, Td): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death.	Initials _____ Date _____
<input type="checkbox"/>	Pertussis (Whooping Cough) (DTaP, Tdap): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Polio: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death.	Initials _____ Date _____
<input type="checkbox"/>	Measles, Mumps, Rubella (MMR): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and brain damage.	Initials _____ Date _____
<input type="checkbox"/>	Haemophilus Influenza type b (Hib): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing Hib if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, and death.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis B: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis A: I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death.	Initials _____ Date _____
<input type="checkbox"/>	Varicella (Chickenpox): I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death.	Initials _____ Date _____

Due to my religious beliefs, I request an exemption for my child from the required vaccine doses selected above. I am aware that if I change my mind in the future, I can rescind this exemption and obtain immunizations for my child.

Initials _____

- I am aware that additional information about vaccine preventable diseases, vaccines and reduced or no cost vaccination services is available from my local county health department and Arizona Department of Health Services (www.azdhs.gov/phs/immun/).
- I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend child care until the risk period ends, which may be 3 weeks or longer.

Child's Name _____ Date of Birth (month/day/year) _____

Parent/Guardian Signature _____ Date (month/day/year) _____