



Registration

Fall 2010-Spring 2011

301 Hays Country Acres Rd. ~ Dripping Springs TX 78620 ~ 512.858.4924
web: www.discoverydayschool.org email: mmilligan@discoverydayschool.org

Tuition and Fee Agreement

Child's Name: _____ **Date of Birth:** _____

Address City Zip: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Sprouts - 18 months	8:30-12:30	12:30-2:30
Tue/Thur	\$200	<i>Not Available</i>
Buds - 2 years	8:30-12:30	12:30-2:30
Tue/Thur	\$180	<i>Not Available</i>
Blooms - 3 years	8:30-1:30	1:30-2:30
Tue/Wed/Thur	\$305	\$20
Jumpstart - 4 years	8:30-1:30	1:30-2:30
Mon-Thur	\$405	\$20

Registration Fee: \$25 and ½ first month's tuition due at time of registration (non-refundable.) Payment will not be deposited until August 1st but must be in hand at time of registration. Child is not enrolled until registration fee and forms are received by the program director.

Snack: One snack per day will be supplied by the Discovery Day School program.

Supply Fee: 4 day program \$100 annually, 3 days \$75 annually, 2 days \$50 annually. One time payment by start date or half payment due within a month of each semester start date and is nonrefundable.

Tuition: Remainder of September tuition is due in full by September 1st and the rest on the 1st of each month. Mid year registration tuition is due by start date. All checks should be made payable to ECHS Discovery Day School. A \$25 fee will be charged for all returned checks.

Late Fee: There will be a \$20 late charge for payments received after the 10th of the month.

Discounts: \$10 per each additional sibling.

Parent Signature: _____ **Date:** _____

Parent's Name (Print): _____

Please make checks payable to ECHS DDS.



Discover Day School Registration Fall 2010-Spring 2011

Child's Name: _____ Date of Birth: _____
Address City Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____

Parents Are (circle): Married Divorced Separated Single

Should the child be under the legal custody of only one parent, a copy of the final court judgment must be on file at The Episcopal Church of the Holy Spirit.

Mother or Guardian:

Name _____ TXDL #: _____
Church Affiliation: _____
Employer: _____ Occupation: _____
Business Phone: _____ Cell Phone: _____

Father or Guardian:

Name _____ TXDL #: _____
Church Affiliation: _____
Employer: _____ Occupation: _____
Business Phone: _____ Cell Phone: _____

Brothers and Sisters (Names & Ages):

Is your child toilet trained? Yes / No What words does your child use for toilet?

Children must be potty trained in order to enroll in the 3 year old class.

Enrollment is not complete until all forms and payment are turned into the program director.
Payment must accompany this registration form to hold a space in the class for your child.
Checks should be made payable to ECHS DDS.
This registration payment is not refundable.



Emergency Information & Release

Fall 2010-Spring 2011

Child's Name: _____ Date of Birth: _____
Insurance Co: _____ Policy#: _____
Physicians Name: _____ Phone: _____
Address: _____
Hospital/Clinic: _____ Phone: _____
Address: _____

Emergency Contact Phone Numbers

Work Numbers:
Mother/Guardian: _____ Father/Guardian: _____
Mobile Numbers:
Mother/Guardian: _____ Father/Guardian: _____

Alternate Persons for Emergency Contact and School Pickup:

Name: _____ Address: _____
Relationship: _____ Phone: _____
Name: _____ Address: _____
Relationship: _____ Phone: _____

Parental Permission:

1. I give my permission for my child to participate in all regularly planned activities and field trips.
2. I give my permission to have my child in any media coverage approved by The Episcopal Church of the Holy Spirit.
3. I hereby release The Episcopal Church of the Holy Spirit, its officers and representatives of all liabilities arising out of enrollment in this program.

In the event that I cannot be reached to arrange for emergency medical attention at the time of an illness or accident, I hereby give consent to the program director, or representatives of The Episcopal Church of the Holy Spirit and/or Program to take my child to the above named hospital/clinic or the closest hospital/clinic for any and all necessary treatment. I also assume all financial responsibility.

CAUTION: No medications will be stored at school or administered by staff. The Episcopal Church of the Holy Spirit Discovery Day School Program and its representatives will not administer medications at any time, as stated in the program Parent Handbook.

Parent Signature: _____ Date: _____
Parent's Name (Print): _____



Discovery Day School

My Teacher and Me

Fall 2010-Spring 2011

Child's Name: _____

Parents Names: _____

Email Contact: _____ Phone: _____

Mailing Address: _____

Allergies & reactions to them:

Special health conditions & descriptions:

Blood Type: _____

Toileting: Not potty trained Starting potty training Ready to go!

How can we help? _____

Child's Favorites:

Foods _____

Toys _____

Activities _____

Child's Behavior:

Any special fears? _____

What comforts your child? _____

What stops misbehavior? _____

What is used for distraction? _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____

Medical Information

All children must be up-to-date on their immunizations to be eligible to attend school. In order to comply with state requirements, a current copy of your child's immunization record signed by the physician or a health professional must be on file at The Episcopal Church of the Holy Spirit. It is required by the State of Texas that each child must have been seen by a physician within the last 12 months to assess the health of the child.

Name of Child: _____ **DOB:** _____

Immunizations	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Booster	Date/Booster
DTP / DTaP / DT					
POLIO IPV					
MEASLES					
MUMPS					
RUBELLA					
HIB					
HEPATITIS A					
HEPATITIS B					
TB TEST (if required)	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	Date:		
VARICELLA (see below)					

Signature - Physician or Health Personnel _____ Date _____ & Signature - Staff Making Handwritten Copy of Record _____ Date _____

Varicella (chicken pox) vaccine is not required if your child has had chicken pox disease. If your child has had chicken pox, please complete the statement: My child had varicella disease (chicken pox) on or about (date) _____ and does not need varicella vaccine.

Parent Signature _____ Date _____

Check one option only:

If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.

Healthcare Professional Statement: This child was examined by me on _____ (date) and found to be free of all contagious diseases and is physically able, with the exceptions noted, to participate in the Discovery Day School Program at The Episcopal Church of the Holy Spirit.

A signed and dated copy of a health care professional's statement is attached.

My child has been examined within the past year by a health care professional and is able to participate in the program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Physician's Signature: _____ Date: _____

Print Name: _____

Address/City/Zip: _____ Phone: _____

Parent Signature _____ Date _____