



Ray Ellison Family Center Enrollment Application

Section I: Basic Demographics	
Parent or Legal Guardian's Name: <i>(First name, MI, Last Name)</i>	
Physical Address: <input type="checkbox"/> <i>Child lives with me</i>	
City, state, zip code:	
Primary Phone:	Alternate Phone:
Parent or Legal Guardian's Name: <i>(First name, MI, Last Name)</i>	
Physical Address: <input type="checkbox"/> <i>Child lives with me</i>	
City, state, zip code:	
Primary Phone:	Alternate Phone:
Enrolling Child #1 Information	
Child's Name: <i>(First name, MI, Last Name)</i>	
Nickname:	Date of Birth:
	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White
Primary Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	preferred Language spoken at center: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Health Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Assistive devices used by child: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Braces <input type="checkbox"/> Wheelchair/cane <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Other: _____
Diagnosed conditions: <input type="checkbox"/> Respiratory <input type="checkbox"/> Heart <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Swallowing	
Expected days and hours my child will be in care: <input type="checkbox"/> Monday _____ <i>am</i> to _____ <i>pm</i> <input type="checkbox"/> Tuesday _____ <i>am</i> to _____ <i>pm</i> <input type="checkbox"/> Wednesday _____ <i>am</i> to _____ <i>pm</i> <input type="checkbox"/> Thursday _____ <i>am</i> to _____ <i>pm</i> <input type="checkbox"/> Friday _____ <i>am</i> to _____ <i>pm</i>	
I understand that the following meals will be served to my child while in care: <input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack	



Ray Ellison Family Center Enrollment Application

Enrolling Child #2 Information		
Child's Name: (First name, MI, Last Name)		
Nickname:	Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic/Non-Latino	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White	
Primary Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	preferred Language spoken at center: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Health Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Diagnosed conditions: <input type="checkbox"/> Respiratory <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Swallowing <input type="checkbox"/> Heart <input type="checkbox"/> Other: _____	Assistive devices used by child: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Braces <input type="checkbox"/> Wheelchair/cane <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Other: _____	
Expected days and hours my child will be in care: <input type="checkbox"/> Monday _____ am to _____ pm <input type="checkbox"/> Tuesday _____ am to _____ pm <input type="checkbox"/> Wednesday _____ am to _____ pm <input type="checkbox"/> Thursday _____ am to _____ pm <input type="checkbox"/> Friday _____ am to _____ pm		
I understand that the following meals will be served to my child while in care: <input type="checkbox"/> None <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack		
Section II: Family Members Demographic Data		
List all family members: Family Size _____ Number of adults _____ Number of children _____		
Name if family member (first name, MI, last name)	Relationship to child	Primary Language
(head of household)		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____



Ray Ellison Family Center Enrollment Application

		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Please indicate occupations status of legal guardian living in the household		
Employed: <input type="checkbox"/> Full time (30+ hours weekly) <input type="checkbox"/> Part time <input type="checkbox"/> Season – Non Agriculture <input type="checkbox"/> Other: _____		In School: <input type="checkbox"/> PAC Full time <input type="checkbox"/> PAC Part time <input type="checkbox"/> Other Alamo College F/T or P/T <input type="checkbox"/> TAMU <input type="checkbox"/> Other: _____
Section III: Family Information		
Family type: <input type="checkbox"/> Two parent family <input type="checkbox"/> Single parent family (mother figure only) <input type="checkbox"/> Single parent family (father figure only)		
<input type="checkbox"/> Foster family <input type="checkbox"/> Other family type <input type="checkbox"/> Other relatives		
Types of services or financial assistance received: <i>(mark all that apply)</i>		
<input type="checkbox"/> No services received <input type="checkbox"/> Unemployment insurance <input type="checkbox"/> SNAP: # _____ <input type="checkbox"/> SSI <input type="checkbox"/> Child support/alimony <input type="checkbox"/> Medical financial assistance (Medicaid/Medicare) <input type="checkbox"/> Public Assistance/Welfare (TANF/AFDC)		
<input type="checkbox"/> EPSDT <input type="checkbox"/> WIC <input type="checkbox"/> Energy Program Assistance <input type="checkbox"/> Public Housing Assistance <input type="checkbox"/> Foster care/ Adoption subsidy <input type="checkbox"/> Interested in Child Care Scholarships <input type="checkbox"/> Other: Specify _____		
Section IV: Emergency Contact Information and Authorization of Drop Off/Pick Up		
Name: <i>(First name, MI, Last Name)</i>		Relationship to child:
Telephone #:	Alternate #:	<input type="checkbox"/> Authorized for drop off <input type="checkbox"/> Authorized for pick up <input type="checkbox"/> Authorized for emergency
Name: <i>(First name, MI, Last Name)</i>		Relationship to child:
Telephone #:	Alternate #:	<input type="checkbox"/> Authorized for drop off <input type="checkbox"/> Authorized for pick up <input type="checkbox"/> Authorized for emergency
Name: <i>(First name, MI, Last Name)</i>		Relationship to child:
Telephone #:	Alternate #:	<input type="checkbox"/> Authorized for drop off <input type="checkbox"/> Authorized for pick up <input type="checkbox"/> Authorized for emergency
Signature of Parent/Legal Guardian:		Date:



Ray Ellison Family Center Enrollment Application

Section IV: Health Information		
Enrolling Child #1 Name:		Date of birth:
Insurance provider type: <input type="checkbox"/> Public assistance (Medicaid) <input type="checkbox"/> Private <input type="checkbox"/> No insurance <input type="checkbox"/> CHIP <input type="checkbox"/> Other: _____		
Insurance provider's name:		ID or Policy number:
Insurance effective date: <input type="checkbox"/> N/A	Insurance expiration date: <input type="checkbox"/> N/A	Dental coverage included: <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary care provider: (doctor/clinic name)		Phone number:
Street, city, state, zip:		
Dental care provider: (doctor/clinic name)		Phone number:
Street, city, state, zip:		
Specialist provider: (doctor/clinic name)		Phone number:
List any other medical needs or concerns that your child may have (<i>e.g.: allergies, existing illnesses, medications prescribed for long-term use, past serious illness, injuries during the past 12 months, and any other information staff should be aware of</i>):		
Section V: Authorization for Emergency medical Attention <i>In the event that I cannot be reached to make arrangements for emergency care of my child, I authorize the Coordinator or person in charge to see medical attention for my child.</i>		
Name and number of licensed physician:		
Name and number of hospital/clinic:		
Name and number of dentist:		
<i>I give consent for any necessary emergency treatment when my child is in the care of the above referenced physician, hospital/clinic, or dentist.</i>		
Signature of Parent/Legal Guardian:		Date:



Ray Ellison Family Center Enrollment Application

Section VI: Family Partnership Agreement and Consent Form		Initials
1.	I consent to the enrollment of child in the Ray Ellison Family Center.	
2.	I agree and understand that my child must be up to date on all immunizations, well-child, and dental exams. (if applicable)	
3.	I agree to sign my child in and out daily on ProCare and classroom sign in/out sheet.	
4.	I agree to have my child signed in by 8:30 am. In the event that my child has a Doctor's appointment, I will bring in by 10 am with a Doctors excuse.	
5.	I agree and understand that my tuition is due every Monday before my child is signed in for the day.	
6.	I agree to notify the Coordinator or person in charge by phone call or via email to pac-refc@alamo.edu if my child is unable to attend school for the day.	
7.	In the event that I cannot make or be reached to make arrangements for emergency medical attention, I authorize the Coordinator or person in charge to secure emergency medical treatment for my child. When possible, treatment may be obtained from the persons described on Section V: Authorization for Emergency Medical Treatment.	
8.	I agree to participate in 2 Parent/teacher conferences each semester my child is enrolled.	
9.	I agree to bring diapers every week and have at least two changes of clothes and one pair of shoes in my child's cubby.	
10.	I understand and have received written information about special Education referrals to local school districts and Part C agency, Early Childhood Intervention (ECI). I agree to follow through with the referral process outlined, if my child is identified with a possible disability.	
11.	I agree and provide consent for Teachers to complete the GOLD Assessment on my child and have received the information regarding developmental assessments.	
12.	I agree to provide the center with a copy of my child's birth certificate or other form that acknowledges date of birth.	
13.	I agree and understand that I must fill out the CACFP Meal Benefit Income Eligibility Form.	
14.	I agree and understand that I must provide proof of income (i.e. most recent W-2, No Income Statement, 1040/1040A, child support, etc.)	
Other Authorizations/Releases		
15.	Share health records with the school system.	
16.	Use of child's photograph	
17.	Water play, such as water hose or sprinkler	
Enrollment Date:		Withdrawal Date:
Signature of Parent/Legal Guardian:		Date:
Signature of REFC Staff:		Date:



Ray Ellison Family Center Enrollment Application

Section VII: Cultural Questionnaire	
Parent/Legal Guardian Name:	
Child's Name:	
1.	What traditions and norms are important to you and your family?
2.	What holidays are important to you and your family?
3.	Are there any foods/drinks that your child cannot consume when attending Ray Ellison Family Center?
4.	Are there any unusual situations at home that might result in added tension or stress? (i.e. illness, new sibling, move, death, etc.)
5.	What language is spoken at home?
6.	What language do you prefer at school?
7.	Is your child on any medication?
8.	Does your child have allergies?
9.	On average how many hours of T.V does your child watch daily?
10.	On average how many hours of screen time does your child get daily?
11.	What are you child's interests?
12.	What are you child's favorite foods?

APPROVED
AS TO FORM ONLY

GENERAL COUNSEL ALAMO COLLEGES