

# CALVARY CHRISTIAN EARLY CHILDHOOD CENTER



1815 N. 7<sup>th</sup> St Harlingen, Texas 78550  
(956) 425-1425 (956) 412-0324 fax  
www.calvarywarriors.org

Student's Name \_\_\_\_\_

Class Entering \_\_\_\_\_ School Year 2023-2024

## INFANT- PRE-K 4

\_\_\_\_ Student's Information & Registration Fee (\$200.00)

\_\_\_\_ Copy of Parent's Current Driver's License

\_\_\_\_ ECC Health Statement

\_\_\_\_ Birth Certificate (New Students Only)

\_\_\_\_ Discipline & Guidance Policy

\_\_\_\_ Immunization Records

\_\_\_\_ ECC Website Release

\_\_\_\_ Student Handbook Acknowledgement

\_\_\_\_ DFPS Admission Information (pgs. 1&2)

\_\_\_\_ ECC Allergy Information

\_\_\_\_ DFPS Health Care Professionals  
Statement (NEW students only)  
Must be signed by a physician (pg. 3)

\_\_\_\_ Authorization and Consent /Child Release

\_\_\_\_ DFPS Health Requirements (pgs. 4-6)

Students will be registered in the following order:

- Priority Registration for Currently Enrolled Calvary Students - Feb. 8
- Siblings of Currently Enrolled Calvary Students - Feb. 15
- Open Registration - Feb. 22

Office Information:

Date received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Received by \_\_\_\_\_

Registration fee paid: Cash \_\_\_\_\_ Check # \_\_\_\_\_ Amount \_\_\_\_\_

Cash receipt # \_\_\_\_\_ Credit Card Payment \_\_\_\_\_

\_\_\_\_FACTS

\_\_\_\_SS

\_\_\_\_KD

\_\_\_\_NL

\_\_\_\_LD

\_\_\_\_FILE

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[www.calvarywarriors.org](http://www.calvarywarriors.org)

## STUDENT'S INFORMATION

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Age as of 9/01/23 \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Last School Attended: \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Parent's Email: Mother: \_\_\_\_\_ Email Monthly Statement -YES or NO

Father: \_\_\_\_\_

Name student prefers to be called: \_\_\_\_\_

Student's Mailing Address: \_\_\_\_\_  
Street City State Zip

Student lives with: \_\_\_\_\_ Both Parents \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Guardian

Father's Name (Mr., Dr.): \_\_\_\_\_ Employer: \_\_\_\_\_  
Circle One

Father's Mailing Address (if different from student): \_\_\_\_\_

Father's Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mother's Name (Mrs., Miss, Ms., Dr.): \_\_\_\_\_ Employer: \_\_\_\_\_  
Circle One

Mother's Mailing Address (if different from student): \_\_\_\_\_

Mother's Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother's Cell Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent's Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Remarried \_\_\_\_\_ Single

Friend/ Relative to call in case of illness: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Brother(s) and/or Sister(s) \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

Church Now Attending: \_\_\_\_\_ Member: Yes / No    Active: Yes / No

I understand that in the event of an accident or injury to my child, school personnel will attempt to contact me as soon as possible. It is for this reason all phone numbers and information must be updated and correct. If I or the person I have listed cannot be reached, I hereby give my consent for Calvary Christian Early Childhood Center to arrange for medical treatment. I understand that I will be financially responsible for any medical treatment or service given to my child.

Hospital of Choice: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor of Choice: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child take prescription medication on a regular basis?    Yes (please list)                      No

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any other health problems? \_\_\_\_\_

Special Instructions \_\_\_\_\_

I, the undersigned, have given correct and complete information on the requested answers, and I agree to inform Calvary Christian School if the status of any of the above items changes during the current school term.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

Calvary Christian Early Childhood Center does not discriminate on the basis of race, color, national or ethnic origin in administration of educational policies, admission policies, or athletic and other school administered programs.

I have read the 2023-2024 Parent / Student handbook, as posted online at [www.calvarywarriors.org](http://www.calvarywarriors.org), and I understand and will abide by the policies and procedures.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

# CALVARY CHRISTIAN EARLY CHILDHOOD CENTER

## Child's Allergy Information

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergen:

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Symptom:

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Treatment:

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\*If treatments require medication administration, it will be necessary to have medication authorization paperwork and the physician's signature must be in place as required.

Does child need Epi-pen-----YES/ NO

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Further Emergency Response  
Procedures:

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Additional  
Information/ Instructions \_\_\_\_\_

\_\_\_\_\_ I know of no known food allergy at this time, no dietary adjustments needed.

I understand that Calvary Christian Early Childhood Center requires the most up-to-date information regarding my child's allergy. I also understand that for the safety of my child, all allergy information will be given to all persons caring for my child.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

## Calvary Christian Early Childhood Center Health Statement

I certify that my child, \_\_\_\_\_, has been examined by a licensed physician within the last year and is able to participate in the school program.

Examining Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* A Medical Authorization Form (available in the office) must be filled out and left in the office for any student to receive over-the-counter or prescription medications.

\*Medication from Mexico will NOT be administered by any school staff unless there are U.S. physician's orders on file approving for the substitution of medication from Mexico. The medication must be labeled by the pharmacy in English.

\*All over-the-counter medications need to be provided by parents in original containers with completed medication authorization form (available in office). (See handbook)

\*Any unused medication left at ECC at the end of the school year will be discarded.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Grade

# Discipline and Guidance Policy for Calvary Christian School Early Childhood Center

- ◆ Discipline must be:
  - (1) Individualized and consistent for each child;
  - (2) Appropriate to the child's level of understanding; and
  - (3) Directed toward teaching the child acceptable behavior and self-control.
- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  - (3) Redirecting behavior using positive statements; and
  - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.
- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  - (1) Corporal punishment or threats of corporal punishment;
  - (2) Punishment associated with food, naps, or toilet training;
  - (3) Pinching, shaking, or biting a child;
  - (4) Hitting a child with a hand or instrument;
  - (5) Putting anything in or on a child's mouth;
  - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  - (7) Subjecting a child to harsh, abusive, or profane language;
  - (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed;and
  - (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Check one please:

☐ parent

☐ employee/caregiver

☐ household member of child-care home

Calvary Christian Early Childhood Center  
Website Release  
www.calvarywarriors.org

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

To inform the family of Calvary Christian Early Childhood Center, Calvary Christian School, Calvary Baptist Church, and the surrounding community, your child's work, name, or picture may be posted on the website. We anticipate utilizing activity and ministry pictures featuring our students, facility, and staff. Your help in the process will be greatly appreciated.

We realize that anyone with internet access will be able to view these pages. We are concerned about privacy and safety of the students. We ask for permission for your child's work and picture to be published on Calvary Christian's website. If you are not comfortable with this, we will honor your request not to publish your child's work or picture.

\_\_\_\_\_ My child's work, name, or pictures may be published on Calvary Christian School's and / or Calvary Baptist Church's webpage.

\_\_\_\_\_ Please do not electronically display my child's work, name, or picture.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**CALVARY CHRISTIAN EARLY CHILDHOOD CENTER  
AUTHORIZATION AND CONSENT/CHILD RELEASE**

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child,\_\_\_\_\_. If I cannot be reached, I understand that the emergency contacts below will be called. However, I authorize Calvary ECC to call an ambulance to transport my child to a hospital and to secure for my child the necessary medical treatment. I understand the staff of the ECC is trained in the basics of first aid and CPR and I authorize them to give my child first aid.

Child's Health Insurance Provider:\_\_\_\_\_

Name of Insured:\_\_\_\_\_ Policy Number:\_\_\_\_\_

To ensure a child's safety, Calvary ECC will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by parent/guardian.

By signing this form, I understand Calvary ECC will not release my child to any person unless I notify the Center in advance, following the guidelines below:

- If the person picking up my child is NOT listed on this form, I must notify the center verbally or in writing.
- Photo identification will be required of any person picking up my child.

Child's Name:\_\_\_\_\_

Date of Birth:\_\_\_\_\_

1. Name:\_\_\_\_\_

Relation:\_\_\_\_\_

Phone #:\_\_\_\_\_

2. Name:\_\_\_\_\_

Relation:\_\_\_\_\_

Phone #:\_\_\_\_\_

3. Name:\_\_\_\_\_

Relation:\_\_\_\_\_

Phone #:\_\_\_\_\_

4. Name:\_\_\_\_\_

Relation:\_\_\_\_\_

Phone #:\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date





## **ADMISSION INFORMATION**

**Purpose:** Use this form to collect all required information about a child enrolling in day care.

**Directions:** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

### **GENERAL INFORMATION**

Operation's Name: Calvary Early Childhood Center and Daycare		Director's Name: Laura De Leon	
Child's Full Name:	Child's Date of Birth:	Child Lives With: <input type="checkbox"/> Both parents <input type="checkbox"/> Dad	<input type="checkbox"/> Mom <input type="checkbox"/> Guardian
Child's Home Address:			
Date of Admission:		Date of Withdrawal:	
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian (if different from the child's):	
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File: <input type="checkbox"/> Yes <input type="checkbox"/> No
Give the name, address, and phone number of the responsible individual <b>to call</b> in case of an emergency if parents/guardian cannot be reached:			Relationship:
I authorize the child care operation <b>to release</b> my child to leave the child care operation <b>ONLY</b> with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name and Phone Number:	Name and Phone Number:	Name and Phone Number:	

### **CONSENT INFORMATION**

#### **CHECK ALL THAT APPLY:**

#### **1. TRANSPORTATION**

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care    ☐ on field trips    ☐ to and from home    ☐ to and from school

#### **2. FIELD TRIPS**

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trips.

**Comments:**

#### **3. WATER ACTIVITIES**

I give consent for my child to participate in the following water activities:

☐ water table play    ☐ sprinkler play    ☐ splashing/wading pools    ☐ swimming pools    ☐ aquatic playgrounds

### CONSENT INFORMATION

#### CHECK ALL THAT APPLY:

#### 4. RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including those for:

<input type="checkbox"/> Discipline and guidance	<input type="checkbox"/> Procedures for release of children
<input type="checkbox"/> Suspension and expulsion	<input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Emergency plans	<input type="checkbox"/> Procedures for dispensing medications
<input type="checkbox"/> Procedures for conducting health checks	<input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Safe sleep	<input type="checkbox"/> Meals and food service practices
<input type="checkbox"/> Procedures for parents to discuss concerns with the director	<input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Procedures for parents to participate in operation activities	<input type="checkbox"/> Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

#### 5. MEALS

I understand that the following meals will be served to my child while in care:

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

#### 6. DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

### AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Phone Number:
Name of Emergency Care Facility:	Address:	Phone Number:
I give consent for the facility to secure any and all necessary emergency medical care for my child.		Signature - Parent or Legal Guardian

### CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature - Parent or Legal Guardian:

Date Signed:

### SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:

School Phone Number:

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

### ADMISSION REQUIREMENT

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Health Care Professional's Signature:

Date Signed:

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

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

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

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:

Date Signed:

### REQUIREMENTS FOR EXCLUSION

- ☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90<sup>th</sup> day after the affidavit is notarized.
- ☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

### VISION EXAM RESULTS

R 20/	L 20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Signature:		Date Signed:	

### HEARING EXAM RESULTS

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature:			Date Signed:	

### VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each* dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose) 1-2 months (second dose) 6-18 months (third dose)	
Rotavirus	2 months (first dose) 4 months (second dose) 6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose) 4 months (second dose) 6 months (third dose) 15-18 months (fourth dose) 4-6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose) 4 months (second dose) 6 months (third dose) 12-15 months (fourth dose)	

### VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Pneumococcal	2 months (first dose) 4 months (second dose) 6 months (third dose) 12-15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose) 4 months (second dose) 6-18 months (third dose) 4-6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12-15 months (first dose) 4-6 years (second dose)	
Varicella	12-15 months (first dose) 4-6 years (second dose)	
Hepatitis A	12-23 months (first dose) The second dose should be given 6 to 18 months after the first dose.	

### PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature :

Date Signed:

### VARICELLA (CHICKENPOX)

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

Parent's Signature: /

Date Signed: /

### ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at [www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm).

**TB TEST (IF REQUIRED)**

☐ Positive

☐ Negative

Date:

**GANG FREE ZONE**

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

**PRIVACY STATEMENT**

DFPS values your privacy. For more information, read our Privacy and Security Policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.

**SIGNATURES**

Child's Parent or Legal Guardian:

X

Date Signed:

Center Designee:

X

Date Signed:



Name: \_\_\_\_\_

Date of Registration: \_\_\_\_\_ Grade: \_\_\_\_\_

**\*PLEASE CIRCLE YOUR SELECTION(S) BELOW\***

### Infant and Toddler Rates

Infants: Ages 6 weeks—17 months / Toddlers: Ages 18 months—2 years

Non-Refundable Registration Fee of \$200 per room

	2 Days per Week Tuesday/Thursday	3 Days per Week Monday/Wednesday/Friday	Full Monthly Daycare 5 Days per Week
<b>Half Day</b> 7:15 AM—1:00 PM	\$150/mo.	\$200/mo.	\$350/mo.
<b>Mid Day</b> 7:15 AM—3:45 PM	\$215/mo.	\$295/mo.	\$480/mo.
<b>Full Day</b> 7:15 AM—5:30 PM	\$250/mo.	\$350/mo.	\$550/mo.

### Pre-School Rates

Ages 2—4 years

Non-Refundable Registration Fee of \$200

	2 Days per Week Tuesday/Thursday	3 Days per Week Monday/Wednesday/Friday	Full Monthly Pre-School 5 Days per Week
<b>Pre-School Class</b> 8:15 AM—12:00 PM	\$160/mo.	\$240/mo.	\$390/mo.

### Pre-School Extended Care Rates

Available to students enrolled in Pre-K 2—Pre-K 4

	2 Days per Week Tuesday/Thursday	3 Days per Week Monday/Wednesday/Friday	Full Monthly Daycare 5 Days per Week
<b>Early Morning</b> 7:15—8:15 AM	\$15/mo.	\$20/mo.	\$30/mo.
<b>Extended Lunch</b> 12:00—1:00 PM	\$15/mo.	\$20/mo.	\$30/mo.
<b>Mid Afternoon</b> 12:00—3:45 PM	\$60/mo.	\$90/mo.	\$150/mo.
<b>Full Afternoon</b> 12:00—5:30 PM	\$70/mo.	\$105/mo.	\$170/mo.

#### Drop-in Daycare

for Pre-K students not paying a monthly daycare fee

\*Early Morning & Extended Lunch—\$5/day

\*Afternoon Daycare—\$5/hour

#### Holiday Fees

\*for Pre-K students paying a monthly daycare fee—\$5/day

\*for students not paying a monthly daycare fee—

\$30/day (8:15 AM-3:30 PM) OR \$40/day (7:15 AM-5:30 PM)

\*Summer Program rates are published in the month of May.

\*Monthly Pre-School Extended Care Rates are prorated in the month of August only.