



The Sherwood Academy

32810 Tamina Road, Magnolia, Texas 77354

Phone: 281-356-4970 Fax: 866-356-3290

Enrollment Information 2018-2019

Parents please fill out ALL information as thoroughly as possible. Failure to fill out all necessary information will result in an incomplete file and delay of your child's admission.

I. STUDENT INFORMATION

Name: _____ Date of Birth: _____

Email Address: _____ Home Telephone: _____

Home Address: _____ City/Zip _____

Days and hours child will be in care: _____

Parent or Guardian's Name: _____

Mother's Cell/Work: _____ Father's Cell/Work: _____

Date of Admission: _____ Date of Withdrawal: _____

Name, phone number, address and relationship of person to call in case of an emergency if parents or guardian cannot be reached:

***List any special problems that your child may have, such as allergies, existing illness, previous serious illnesses, injuries incurred during the last 12 months, any medication prescribed for long-term continuous use, and other pertinent information which the staff of The Sherwood Academy should be aware of:**

II. FINANCIAL OBLIGATIONS

- A **NON-REFUNDABLE** registration fee of _____ is due at time of registration. (Please refer to pricing guide.)
- August's Tuition (prorated 50%) in the amount of _____ is due by July 15th.
- Monthly Tuition in the amount of _____ is to be paid by the first of each month, September through May.
- A \$25.00 late fee will be assessed to all tuition payments received **after the 5th of each month.**
- A \$30.00 returned-check fee will be assessed for all returned checks.
- A **30-day written notice of withdrawal is required.** Your account balance, including any outstanding fees and 30 day notice balance will be due in full at the time of withdrawal.

PARENT SIGNATURE: _____ **DATE** _____

III. AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION / RELEASE INFORMATION

The Sherwood Academy/32810 Tamina Road, Magnolia, TX 77354/281-356-4970/ Fax 866-356-3290

Enrollment Information

Students Name _____

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or the person in charge to take my child to:

Name of Physician: _____ Phone: _____

Name of Hospital: _____ Phone: _____

***I give consent for this facility (The Sherwood Academy) to secure any and all necessary medical care for my child.**

PARENT SIGNATURE: _____

DATE: _____

I hereby authorize my child to leave The Sherwood Academy with **ONLY** the following persons. Please include **names and phone numbers**. Identification will be checked for all persons listed below.

1. _____
2. _____
3. _____
4. _____

IV: PHOTO RELEASE AND POLICIES

Please read all information carefully and **sign**.

I give permission for photos of my child to appear in advertising materials such as news ads, brochures, website and face book promotions. Names are never used in conjunction with photos.

I agree to provide a snack and a lunch (extended day only) each day for my child. 2 snacks are required for children who stay until 5pm. I understand that food services are not provided by The Sherwood Academy. I understand that I will be expected to pay for any snacks or lunches that The Sherwood Academy may have to provide if I fail to provide the necessary snacks or lunches. Snack fee \$4, lunch fee \$8.

I have read and agree to abide by the operational policies set forth in our parent’s handbook, *The ABC’s of The Sherwood Academy* as well as the Additional Policies and Procedures.

I understand that should my child fall ill while I school I will be required to arrange for a pickup. I also understand that I have 30 minutes from the time I am contacted by The Sherwood Academy to pick up my child. I understand that I may incur a late pick up fee beyond the 30 minutes.

I understand that I am responsible for providing all necessary medical records for my child **PRIOR to the start of school. I understand that I am responsible for providing updated copies as needed. I understand that my child will not be allowed to attend class until records are complete. I understand that I am still responsible for tuition payments during the file completion process.**

PARENT SIGNATURE: _____

DATE: _____

Verified By: _____ Date: _____

V: HEALTH REQUIREMENTS

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

To be completed by parent

Please explain all Y answers

Allergies (food, insects, drugs, latex, etc..)	Y	N	
Asthma or Breathing	Y	N	
Behavioral or Emotional	Y	N	
Bladder or Bowel	Y	N	
Coughing	Y	N	
Developmental Delays	Y	N	
Diabetes	Y	N	
Ears or Eyes	Y	N	
Head Injury	Y	N	
Heart	Y	N	
Prematurity	Y	N	
Seizures	Y	N	
Speech/language delays	Y	N	
Other	Y	N	

- A. Please attach a current and up to date copy of your child’s vaccination records or an original, current and notarized affidavit of vaccination exemption.
- B. The Vision and Hearing Program, Chapter 36 of the Health and Safety Code requires that all children enrolled for the first time in any public, private, parochial or denominational school or in a Department of Family and Protective Services licensed child care center and child care home in Texas who meet certain grade criteria must be screened or have a professional examination for possible vision and hearing problems. The requirements for Vision and Hearing Screening apply each year for children enrolled in any licensed child care center and the ages or grades listed: **4 years old by September 1st, all Kindergarteners, any other 1st time entrants 4 years through 12th grade, all 1st graders, 3rd graders, 5th graders and 7th graders.**

To be completed by physician

Vision	L:	R:		PASS:	FAIL:
Hearing– 25db	L;4000	L;2000	L;1000	PASS:	FAIL:
	R;4000	R;2000	L;2000	PASS:	FAIL:

DOCTOR’S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

Physician Signature: _____ **Date:** _____