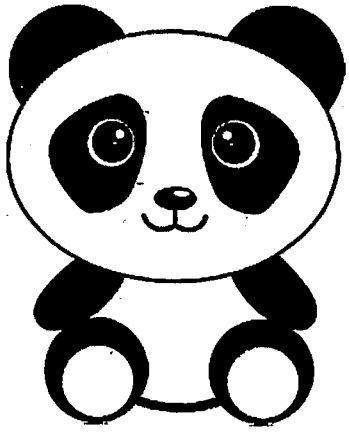
Northwest Local School District

Houston Early Learning Center

PRESCHOOL REGISTRATION PACKET

2020-2021



step up to quality

Ohio's Tiered Quality Rating & Improvement System

Northwest Local School District Preschool Program
2020-2021

The Northwest Local School District is pleased to offer preschool classes at the Houston Early Learning Center.

Preschool students attend five (5) days per week either in the morning or afternoon at the Houston Early Learning Center. Children must reside within the Northwest Local District and must be three or four years of age on or before September 30, 2020 to be eligible to attend this program. *A child must be toilet trained by August 1, 2020 for final acceptance into the Early Childhood Program.*

The Northwest Local School District serves preschool students with disabilities in blended preschool classrooms. This means students with disabilities and typical students are in one classroom. If you feel your child may require services for a disability, please contact the Special Education Services Department at 513-522-6700 extension 4917 for additional information.

The tuition requirement for the Northwest Local District Early Childhood Preschool Program is based on income and is supported by the Northwest Local School District. Support is received through state and federal funds. These funds are based on criteria which must be adhered to including stringent income eligibility components in order for the funds to be retained. One such requirement is the Early Childhood Education Eligibility Screening Tool which you will find in this packet.

Tuition for the 2020-2021 school year will remain at $200 per month. Reduced tuition rates are available for those who qualify.

Class size in preschool classrooms is limited in order to comply with state regulations. Completed registration packets must be submitted to the Houston Early Learning Center at 3308 Compton Rd. Cincinnati, OH 45251. Packets will be accepted until class capacity is met. After that a waiting list is established on a first come, first served basis.

In June, parents will be notified via US Mail of the assigned screening date and time for their child. Teacher assignment and parent-teacher-child conference times and dates will be mailed after the screenings take place. Mandatory screenings will take place in July.

NORTHWEST LOCAL SCHOOL DISTRICT
EARLY CHILDHOOD PRESCHOOL PROGRAM

Document Verification List

Houston Early Learning Center Office
3308 Compton Rd, Cinti, Ohio 45251
Phone (513) 385-8000 Fax (513) 385-8090

Student Name_____ Date of Birth_____
(As it appears on Birth Certificate)

Documents & Forms Required for **PRESCHOOL** Enrollment

Please Complete and Sign the Following FORMS:

_____ Student Enrollment Form
_____ Physical Examination Form *(completed and signed by physician)*
_____ Immunization Record *(completed and signed by physician)*
_____ Dental Form *(completed and signed by dentist)*
_____ Student Health Form
_____ Emergency Medical Authorization Form
_____ Student Dismissal Information
_____ Early Childhood Education Eligibility Screen Tool
_____ Parent Financial Agreement

The following documents MUST be provided:

_____ Child's Birth Certificate or Passport
_____ Court-Stamped Custody Papers *(if applicable)*
_____ Parent/Guardian's Drivers License or State ID
_____ Proof of Residency (2 required)
Current Mortgage, Tax Bill, Commercial Lease OR Residency Affidavit
with Owner's Proof and Business Mail addressed to the Name of the Parent/Guardian
_____ 2 current pay stubs or Employer Letter for Wage Verification
_____ 2019 1040 or 1040 EZ tax form for Dependent Verification*

Registration forms must be completed and documents must be provided at the time of registration.*
**2019 Tax forms are due no later than April 30, 2020*
**Physical and Dental forms are due no later than June 2, 2020*
Failure to turn in the required paperwork will result in removal from the preschool class list.

Northwest Local School District

Early Childhood Student Enrollment Form

Please Circle Choice(s): AM 7:55 am-10:45am PM 12:10pm-3:00pm

Student Name _____ _____
First Middle Last

Grade _____ **Date of Birth:** _____ **Place of Birth:** _____

Home Address _____ **Home Phone** _____

Circle One: White Black Hispanic** Asian Multiracial* American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander

**If Hispanic, Select Racial Group: Cuban Mexican Puerto Rican South or Central American Other Spanish Culture

*If Multi-Racial, Select Racial Groups: White Black/African American Asian American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander

Circle One: Male Female **Last School Attended** _____ **Age** _____

Last District Attended _____

If born outside of US, give date of entry _____

Parent Information:

Status of Parents (circle one): Married Divorced Widowed Separated Single/Never Married

Are you the natural/adoptive parent(s) of the child (circle one): Yes No If no, your relationship: _____

Father/Guardian:	**Mother/Guardian:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Home Phone: _____	Home Phone: _____
Cell/Pager: _____	Cell/Pager: _____
Email: _____	Email: _____
Place of Employment: _____	Place of Employment: _____
Business Phone: _____	Business Phone: _____
Step-Mother (if applicable): _____	Step-Father (if applicable): _____
Work Phone: _____	Work Phone: _____

Home Language Survey:

1. What language did your son/daughter speak when he/she first learned to talk? (Native Language) _____
2. What language does your son/daughter use most frequently at home? (Home Language) _____
3. What language do you use most frequently with your son/daughter? _____
4. What language do the adults at home most often speak? _____
5. How long has your son/daughter attended school in the United States? _____

Special Services: Has your child received any of the following services? (Please check all that apply)

☐ Multifactor/Psychological Evaluation ☐ Individual Education Plan (IEP) ☐ ESOL Services

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Annual Class Roster: Each year we prepare a roster for each classroom in our program. This roster will not be furnished to any person (s) other than parents of children enrolled in our program. I authorize the following information to be listed on the parent roster:

My Child's Name, Parent/Guardian name, Address and Phone Number: ☐ Yes ☐ No Signature of Parent/Guardian _____
Date: _____

Other Siblings In The District:

Name: _____ Grade: _____ Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____ Name: _____ Grade: _____

I, the undersigned, do hereby state and declare under penalty of falsification (*), that I am the parent or legal guardian of the above named student and that this registration information is true and correct. Consent is hereby granted to Law Enforcement Officers to look at my child's records and make copies, thereof, if the matter of a missing child develops.

_____
Parent/Guardian Signature **Date**

(*) Falsification under Ohio Revised Code Section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of $1,000 or both. REV1/2018

Immunizations for Child Care, Head Start and Pre-School Attendance:

Please follow the following link to the ACIP Easy-to-read Immunization Schedule for Infants and Children[1],[2]

http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf

Ohio Revised Code 5104.014, Division B:
Each child's[3] caretaker parent shall provide to the center, home, or in-home aide a medical statement, as described in division (D) of this section, indicating that the child has been immunized against or is in the process[4] of being immunized against all of the following diseases:

1. Chicken pox;	6. Influenza;	11. Poliomyelitis;
2. Diphtheria;	7. Measles;	12. Rotavirus;
3. Haemophilus influenzae type b;	8. Mumps;	13. Rubella;
4. Hepatitis A;	9. Pertussis;	14. Tetanus.
5. Hepatitis B;	10. Pneumococcal disease;	

Ohio Revised Code 5104.014, Division C:
A child is not required to be immunized against a disease specified in Division (B) of this section if any of the following is the case:

1. Immunization against the disease is medically contraindicated for the child;
2. The child's parent or guardian has declined to have the child immunized against the disease for reasons of conscience, including religious convictions;
3. Immunization against the disease is not medically appropriate for the child's age.

In the case of influenza, a child is not required to be immunized against the disease if the seasonal vaccine is not available.

Ohio Revised Code 5104.014, Division D:
The medical statement shall include all of the following information:

1. The dates that a child received immunizations against each of the diseases specified in division (B) of this section;
2. Whether a child is subject to any of the exceptions specified in division (C) of this section.
3. The medical statement shall include a component where a parent or guardian may indicate that the parent or guardian has declined to have the child immunized.

Follow the link below to the Ohio Department of Jobs and Family Services' Child Medical Statement:

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=01305

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[1] Vaccine doses are only considered **valid** if administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices.

[2] Vaccine doses administered **≤ 4 days** before the minimum interval or age are **valid** (grace period). Doses administered **≥ 5 days earlier** than the minimum interval or age are **not valid** doses and should be repeated as age-appropriate. **If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.**

[3] **"Child" includes both of the following:** 1)An infant, toddler, or preschool age child; and 2) A school-age child who is not enrolled in a public or nonpublic school but is enrolled in a child day-care center, type A family day-care home, or licensed type B family day-care home or receives child care from a certified in-home aide.

[4] **"In the process of being immunized"** means having received at least the first dose of an immunization sequence and complying with the immunization intervals or catch-up schedule prescribed by the director of health (in accordance with the ACIP catch-up schedule).

Early Childhood Preschool
PHYSICAL EXAMINATION FORM

1/20

Student Name _____ DOB _____ Gender _____

School _____ Age _____

Date of Exam: _____ Height _____ Weight _____

General Exam;

Evaluation	Normal	Abnormal	Evaluation	Normal	Abnormal
Skin			Abdomen & Groin		
Posture/Gait			Genitalia & Urinary		
Speech/Communication			Bones/Joints		
Head			Neurological		
Eyes			Gross & Fine Motor		
Ears			Muscles		
Nose			Cognitive		
Mouth/Teeth etc.			Self Help		
Heart & Circulatory			Social Skills		
Chest & Lungs			Glands Thyroid/Lymph		
Weight			Other:		

_____ _____

Vision Screening Results: **RIGHT** 20/_____ **LEFT** 20/_____

Hearing Screening Results: P / F

Lead_____ Blood Pressure_____ Hct/Hgb_____

Allergies:_____

Chronic Condition(s): _____ **Immunizations on Schedule?** YES NO
(A copy of immunizations must be attached)

ABNORMAL FINDINGS/DIAGNOSIS	*PLAN OF ACTION* (If needed, attach physician order for school use)	*RECOMMENDED FOLLOW-UP AND TIME FRAME*

This child has been examined and is in suitable condition for participation in group care. The child has had the age appropriate immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school or is to be exempted from immunizations for the following reason(s):

_____

_____
Physician Signature

_____
Date

Physician Name _____
(Please Print)
Address _____

Phone Number _____
Fax Number _____

Ohio Department of Health Immunization 1-800-282-0546 **Hamilton County - Immunization Program 513-946-7882**

EARLY CHILDHOOD PRESCHOOL
DENTAL FORM

Student's Name _____ Date of Birth _____ Sex _____

School _____ Age _____

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of the above-named student and I find:

- Oral hygiene is: Good Fair Poor
- Number of teeth filled _____
- Number of teeth extracted _____
- All necessary dental work has been completed _____ Yes _____ No
- Treatment is in progress _____ Yes _____ No
- No dental work is necessary _____ Yes _____ No
- Is child under regular dental supervision? _____ Yes _____ No

REMARKS

Please elaborate on any of the above or make any recommendations that would assist the school in helping this child.

_____

_____

_____

_____

DATE OF EXAM _____

Dentist's Signature _____ Date _____

Office Address _____

_____

Phone Number _____

Fax Number _____

PLEASE RETURN THIS COPY TO SCHOOL

Northwest Local School District
Student Health History
2020-2021

(To be completed by parent/guardian)

STUDENT'S LAST NAME _____ FIRST _____ MIDDLE _____ DATE OF BIRTH _____

Parent/Guardian Contact Information _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

FAMILY HEALTH HISTORY - Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father: _____

Mother: _____

Brothers and Sisters: _____

I. HEALTH CONDITIONS - please check any that apply to your child

_____ Abdominal Spinal Curvature (scoliosis etc.)	_____ Diabetes	_____ Meningitis or Encephalitis
_____ ADHD/ADD	_____ Diarrhea/Constipation (chronic)	_____ Neuromuscular Disorder
_____ Allergies – Food***	_____ Eating Problems	_____ Seizures/Epilepsy
_____ Allergies – Medication	_____ Ear Problems/Hearing Difficulty	_____ Sickle Cell Anemia
_____ Allergies – Other_____	_____ Eczema	_____ Skin Rashes (frequent)
_____ Anemia	_____ Emotional Problems	_____ Stool Soiling
_____ Asthma	_____ Hearing Aids	_____ Speech Problems
_____ Behavior Problems	_____ Headaches (frequent)	_____ Throat Infection (frequent)
_____ Birth or Congenital Malformation	_____ Hearing Aids	_____ Tics/Nervous Twitches
_____ Bone/Muscle/Joint Problems	_____ Heart Problems	_____ Traumatic Brain Injury
_____ Bowel/Bladder Problems	_____ Hemophilia	_____ Vision Problems
_____ Cancer – Type_____	_____ Juvenile Arthritis	_____ Urinary Tract Infections
_____ Chicken Pox	_____ Lead Poisoning	_____ Wetting (day/night)

II. VISION AND HEARING

Frequent ear infections? _____ Left Right Both How Often? _____

Hearing problems? _____ When? _____ Ear Tubes? _____

Wears glasses? _____ Reason _____ Date of Last Eye Exam _____

III. INJURIES AND ILLNESS - Please list any severe injuries or illnesses:

Injuries/Illness	Child's Age	Hospitalization
_____	_____	_____
_____	_____	_____

Comments: _____

_____

IV. ADDITIONAL INFORMATION

What medications are given daily or frequently? _____

This child is usually: _____ Very Active _____ Normally Active _____ Inactive

Do you have any concern about how your child gets along with others? _____

_____

Do you have other comments/concerns about this child's health, development, behavior, family or home life that you would like to share with the school?

Please explain/comments _____

_____

V. PAST OR PRESENT SERVICES RECEIVED

☐Previous Psychological Evaluation _____ Year ☐Counseling or Mental Health Services _____ Year

☐Special Education Support _____ Year ☐Speech Therapy _____ Year

DATE OF LAST PHYSICAL EXAM: _____ DATE OF LAST DENTAL EXAM: _____

FORM COMPLETE BY: _____ **RELATIONSHIP TO CHILD:** _____

☐ I hereby authorize the school nurse and/or school health service specialist to share necessary health information about my child with the appropriate school staff.
This information will be shared in a confidential manner. This authorization is valid for the current calendar school year only.
I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Parent/Guardian Signature _____ Date _____

☐ I do not give permission to share information

Parent/Guardian Signature _____ Date _____

2020-2021

EMERGENCY MEDICAL AUTHORIZATION AND AUTHORIZATION TO PICK UP FROM SCHOOL

Student's Name_____ Date of Birth _____ Grade _____

Address _____ Home Phone Number _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority and/or are permitted to pick up the child if he/she becomes ill or injured, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT:

Parent/Guardian (Custodial Guardian)

Mother's Name _____ Telephone # during School Hrs _____

e-mail _____ cell phone # _____

Father's Name_____ Telephone # during School Hrs _____

e-mail _____ cell phone # _____

Do mother & father live in the same house? Y N If not, who has legal custody? **Mother** **Father** **Shared**

Name of Two Relatives or Friends *(Required)*

(1) Who may be notified _____ Phone _____

Address _____ Relationship to Student _____

(2) Who may be notified _____ Phone _____

Address _____ Relationship to Student _____

Doctor to be called _____ Phone _____

Dentist to be called_____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. Preferred local hospital _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: _____

_____

Date _____Signature of parent/guardian_____

Address _____

_____

PART II - REFUSAL TO CONSENT:

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to: _____

_____

Date _____ Signature of parent/guardian _____

Address_____

_____

2020-2021

Session: _____

EARLY CHILDHOOD
STUDENT DISMISSAL INFORMATION

Teacher: _____

(Please complete this form in blue or black ink.)

Student's Name: _____ Nickname: _____ Birthdate: _____

Home Address: _____ Zip: _____ Phone #: _____ (Unlisted?)

E-mail address: _____

Do mother and father live in the same house? Yes No

If not, who has legal custody? (Court documentation must be provided.)

Mother Father

Shared **(If custody is shared, please provide address of both parents.)** Other: _____

Father's Name: _____ Address: _____

Place of Employment: _____ Work Hours from _____ to _____

Work Phone #: _____ Cell #/Pager #: _____ e-mail address: _____

Mother's Name: _____ Address: _____

Place of Employment: _____ Work Hours from _____ to _____

Work Phone #: _____ Cell #/Pager #: _____ e-mail address: _____

Step-Parent's Name: _____ Address: _____

Place of Employment: _____ Work Hours from _____ to _____

Work Phone #: _____ Cell #/Pager #: _____ e-mail address: _____

Guardian's Name: _____

Place of Employment: _____ Work Hours from _____ to _____

Work Phone #: _____ Cell #/Pager #: _____ e-mail address: _____

Babysitter's Name: _____ Address: _____

Phone #: _____ Cell #/Pager #: _____

Please list all other children in your household who attend Northwest Local Schools: _____

_____

MANDATORY EMERGENCY CONTACTS: Please list at least two people who are permitted to pick up your child if he/she were ill and you could not be reached. Please list in the order you prefer called, making sure we have the **DAYTIME PHONE NUMBER**; we must be able to reach someone during the day!

Name: _____ Relationship: _____ Daytime Phone #: _____

Name: _____ Relationship: _____ Daytime Phone #: _____

Name: _____ Relationship: _____ Daytime Phone #: _____

IS THERE ANYONE WHO IS **NOT** TO PICK UP YOUR CHILD?

_____ Relationship: _____

Signature: X _____ Relationship to Student: _____ Date: _____

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name (First, Middle, Last)	Relationship to You (spouse, son, friend, etc.)	Race	Hispanic or Latino Y or N	Spoken Language	Date of Birth	Gender M or F	U.S. Citizen Y or N
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Tell us about your needs for your child(ren)

Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) *Check all that apply*
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			

Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			

Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule *(please list times)*
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____

Do you or anyone in your household pay Child or Spousal Support? ☐ Yes ☐ No

How Much?

Signature of Applicant	Date

Northwest Local School District
Early Childhood Preschool Program

Please complete this form and submit at the time of registration. Every effort will be made to honor parents' session preferences. However, the principal reserves the right to assign students to classes based on the needs of the school and district.

PARENT FINANCIAL AGREEMENT

A COMPLETED TUITION SUBSIDY FORM WILL DETERMINE ELIGIBILITY FOR TUITION ASSISTANCE*

1. I agree to pay the tuition fee in advance with no deduction for absences, holidays, or vacations. The monthly tuition fee is due by the 25th of the prior month for that month of enrollment. For example, the bill for September is due August 25th. I understand that legal action will be taken to collect unpaid obligations.

   ☐ I agree that if my child is enrolled in preschool and the fee is not paid by the final notice from the treasurer's office, my child will be withdrawn from the Houston Early Learning Center preschool. The Northwest Local School District does not have payment plans available for families who are unable to pay the tuition.

2. I also agree to pay the first month's tuition fee prior to the first day of my child's attendance.

3. I agree to pay a $30.00 fee for a returned check and will submit a money order for future payments.

4. I agree to submit any program changes for my child in writing. I understand that changes will become effective the first day of the following month.

5. I understand that my child will not be able to enroll in any future tuition programs within the Northwest Local School District if there are past due balances on my account.

Child's Name _____ Date of Birth _____

Address _____

Parent(s) Name _____ Home Phone _____

Work Phone _____

Cell Phone _____

Parent Signature _____