**REGISTRATION FORM**

**TOMORROW'S PROMISE MONTESSORI SCHOOLS**

Tomorrow's Promise Montessori School 2817 Old Houston Road, Huntsville, TX 77340

Tomorrow's Promise Children's House 906 10th Street, Huntsville, TX 77320

Tomorrow's Promise Academy 1157 Veterans Memorial Parkway, Huntsville, TX 77340

| Today's Date: | Entry Date: | | |
|---|---|---|---|
| Childs Name: | Age: | Sex: | Birthdate: |
| Parent's Name: | Parent's Name: | | |
| Address: | Address: | | |
| Zip: | Zip: | | |
| Cell Phone: | Cell Phone: | | |
| Employer: | Employer: | | |
| Business Phone: | Business Phone: | | |
| Texas Driver's License: | Texas Driver's License: | | |
| Email Address: | Email Address: | | |

Child Lives with (circle one) both parents, mother, father, other________________________________

*******************************************************************************************

Give the name, address and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached. (Address MUST be filled in. This is where the police would take your child if you were in an accident, per child licensing)

Name: ____________________ Relation: ____________________ Phone: ____________________

Address: ____________________ City: __________ State: __________ Zip: __________

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I authorize Tomorrow's Promise, Inc. to release my child to the school ONLY with the following persons. Please list name and telephone number for each person. Children will only be released to a parent, guardian, or a person designated by the parent/guardian after verification of ID.

Name: ______________________________ Relation: __________ Phone: ____________________

Name: ______________________________ Relation: __________ Phone: ____________________

Name: ______________________________ Relation: __________ Phone: ____________________

Name: ______________________________ Relation: __________ Phone: ____________________

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Please circle how you heard about us. Facebook Instagram Friend Website Google Yelp Referral Huntsville Item School Sign Workforce Dolly Parton Imagination Library Other:___________________

Child's previous child care / school (if applicable).__________________________________________________

Are there any problems we need to be aware of (biting, hitting, spitting, bad words, etc)?__________

Parent conferences are available by request at any time, at a minimum we schedule two during the year in the fall and spring for the older children.

All children regardless of race, color, creed, national, or ethnic orgin are eligible for enrollment at all Tomorrow's Promise locations.

**Signature:** ____________________________________________ **Date:** ____________________

BW________ BW Billing_________ QB__________ QB Billing_________ DB__________ Filed_________

**PARENT ORIENTATION**

Child's Name______________________________________________________

Name of parent/guardian____________________________________________

__________ Introduction to staff
__________ Parent visit with the classroom caregiver
__________ Overview of the parent handbook
__________ Policy for arrival and late arrival
__________ Opportunity for an extended visit in the classroom by both myself and my child for a period of time to allow us both to be comfortable
__________ An explanation of the Texas Rising Star Program
__________ Encouragement to share elements of my CCS (Child Care Subsidy) enrollment, so that the provider may assist, if applicable
__________ Family support resources and activities in the community
__________ Child development and milestones
__________ Expectations of families
__________ The significance of consistent arrival, including
  __________ before the educational portion of the school begins
  __________ impact of disrupting other children's learning
  __________ the importance of consistent routines in preparing children for the transition to Kindergarten
__________ Statement about limiting technology use on site to improve communication between staff, children, and families
__________ Statement reflecting the role and influence of families

__________ Under the Texas Penial 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 penalities.

__________ I acknowledge receipt of the facility's operational policies, including those for:
  __________ Procedures for release of children
  __________ Emergency Plans
  __________ Safe Sleep
  __________ Meals and food service practices
  __________ Discipline and guidance
  __________ Illness and exclusion criteria
  __________ Procedures for conducting health checks
  __________ Procedures for dispensing medications
  __________ Immunization requirements for children
  __________ Suspension and expulsion
  __________ Procedures for Parents to discuss concerns with the director
  __________ Procedures for parents to participate in operation activities
  __________ Procedures to visit the center without securing prior approval
  __________ Procedures for parents to contact Child Care Licensing (CCL), Texas Department of Family and Protective Services (DFPS), Child Abuse Hotline, and CCL website

Please download the Brightwheel app on your phone, you will receive an invitation to join for communication and billing purposes.

Parent Signature_____________________________________________________________Date_________________

Director or Assistant Director Signature___________________________________________Date_________________

**ADMISSION REQUIREMENT**

If your child does not attend public school away from Tomorrow's Promise one of the following must be presented when your child is admitted.

1.________ Health Care Professional's Statement: I have examined the above named within the past year and find that he or she is able to take part in the school program.

_______________________________________________ _______________________

Signature/Stamp----Health Care Professional Date

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

3.________ Medical diagnosis and treatment conflict with the tenents and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed 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 school program. **Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to Tomorrow's Promise.**

Child's Doctor and contact information must be provided, if you have chosen 1,2, or 4 above.

Child's Physician________________________________________________________ Phone#__________________

Physician's Address______________________________________________________ Zip code_________________

Parent Signature__________________________________________________________Date__________________

**This form mmst be signed by your doctor YEARLY**

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**Four year old's must have the following documentation**
**Vision Exam Results**

**Right Eye 20/** **Left Eye 20/** **__________ Pass** **__________ Fail**

**Signature____________________________________________________________Date Signed____________________**

**Hearing Exam Results**

| **Ear** | **1000Hz** | **2000Hz** | **4000Hz** | **Pass or Fail** |
|---|---|---|---|---|
| **Right** | | | | **_____Pass ______Fail** |
| **Left** | | | | **_____Pass ______Fail** |

**Signature___________________________________________________________Date Signed____________________**

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**IMMUNIZATION RECORD**

The following immunizations require multiple doses over time and dates thereof (mo. Day. Yr.) are required by the Department of Human Services and must be verified by a licensed physician. Diphtheria, Tetanus, Pertussis (D,T,a P) Haemophilus Influenza Type B (HIB), Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Rubella (MMR), Pneumococcal, Poliovirus (inactivated), Rotavirus, and Varcella (chickenpox)

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

**Please attach a copy of your immunization record**

Special problems or occurrences affecting your cild will be brought to your attention. This includes communicable diseases.

Child's Name:_____________________________________________ Date of Birth:__________________

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND MEDICAL STATEMENT**

In the event I cannot be reached to make arrangements for emergency medical care at the time of illiness or accident, I hereby authorize Tomorrow's Promise Inc to take my child to the nearest licensed physician or hospital. My child physician or hospital. My child is enrolled in an ongoing health supervision program with annual evaluations.

Parent's Signature: ______________________ Date: ______________

Does your child have any **diagnosed food allergies?** No________ Yes_______

If yes, medical plan submitted on:________________________________

List your child's special needs (allergies, existing illnes, or medical conditions, previous serious illiness and injuries, hospitalizations during the past 12 months and any medication prescribed for long-term continous use)
If this does not apply to your child, please indicate with N/A. __________________________________________________

________________________________________________________________________________________________

Child 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).

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I agree to pay the tuition of $________in advance on the 1st of each month. If the 1st falls on a Saturday or Sunday payment is fue on the Friday before. Statements will be sent in Brightwheel. A late fee of $25.00 will be assessed if payment is not received by noon on the 5th. I have read and accept the policies of Tomorrow's Promise and release the school, directors and staff from any liability for injuries, accidents, or illiness occurring while attending Tomorrow's Promise, Inc.

I give consent for my child to be transported and supervised by TPMS employees: __________ field trips (children 5 and over) __________ to and from public school (children 4 and older)

I give my permission for my child to participate in the following water activities when under school supervision:
_____Water table play ______sprinkler play______splashing/wading pools_____swimming pools_____water park

__________ I understand my child's picture, video or movie will be used on our social media platforms, website, and/or advertising. (Last names of children are not used in any advertising)

__________ I understand that there will be no tuition deductions for holidays, illines and vacations or for any other reasons.

__________ Thirty (30) days written notice is required when withdrawing your child from school in order to receive any receive any refunds.

__________ I understand that the school has a camera system and that my child and I may be recorded on camera in common areas. (Cameras are not in restrooms) These images are not for anyone to view except management.

__________ When dropping off my child I will leave him/her under the supervision of a staff member and sign him/her in. When I leave with my child for the day I will sign him/her out.

__________ I understand that my child will be released only to me or persons I authorize.

__________ I have read the parent handbook.

I plan to leave my child at school between the hours of___________ and ___________.

__________ Collection Charge Notice - A service charge of 1.5% per month or 18 APR will be added to overdue accounts. You are also liable for all leagal fees and collection fees.

Parent's Signature_______________________________________________________Date_________________

**After School Parents Only**

My child attends the following school:________________________________________phone#___________

__________ My child's required immunizations and vision/hearing screening are current and on file at their school

__________ My child has permission to be released to the care of his/her sibling under 18 years old.

Parent's Signature__________________________________________________Date___________________

## ENROLLMENT FORM - Tomorrow's Promise, Inc.

Please complete boxes 1-6, then sign and date.

| CHILD NUMBER 1 | | |
|---|---|---|
| 1. Child's Name: | 2. Date of Birth: | 3. Enrollment Date: _________<br><br>Withdrawal Date: __________ |
| 4. Days in Care (mark all that apply):<br><br>________ Monday<br>________ Tuesday<br>________ Wednesday<br>________ Thursday<br>________ Friday | 5. Hours your child is normally Care:<br><br>Start Time: ____________<br><br>End Time: _____________ | 6. Meals your child is served while in care:<br><br>Breakfast<br>Lunch<br>PM Snack |

| CHILD NUMBER 2 | | |
|---|---|---|
| 1. Child's Name: | 2. Date of Birth: | 3. Enrollment Date: _________<br><br>Withdrawal Date: __________ |
| 4. Days in Care (mark all that apply):<br><br>________ Monday<br>________ Tuesday<br>________ Wednesday<br>________ Thursday<br>________ Friday | 5. Hours your child is normally Care:<br><br>Start Time: _____________<br><br>End Time: _______________ | 6. Meals your child is served while in care:<br><br>Breakfast<br>Lunch<br>PM Snack |

| CHILD NUMBER 3 | | |
|---|---|---|
| 1. Child's Name: | 2. Date of Birth: | 3. Enrollment Date: _________<br><br>Withdrawal Date: __________ |
| 4. Days in Care (mark all that apply):<br><br>________ Monday<br>________ Tuesday<br>________ Wednesday<br>________ Thursday<br>________ Friday | 5. Hours your child is normally Care:<br><br>Start Time: ____________<br><br>End Time: _____________ | 6. Meals your child is served while in care:<br><br>Breakfast<br>Lunch<br>PM Snack |

Parents Signature Date of Signature

In accordance with Federal law and the U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866)632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800)845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**PLEASE COMPLETE THIS FORM IF YOUR CHILD IS UNDER 12 MONTHS OLD**

# CACFP INFANT FEEDING PREFERENCE

Center/Provider Name:______________________________________________

This child care provider offers the following infant formula(s):____________________

Infant's Name__________________ Infant's Date of Birth__________________

**Breast milk and/or Formula preference**

| **Please mark your preference** (choose all that apply) | **Today's Date** ________ **Birth through 5 months** | **Today's Date** ________ **6 – 11 months** |
|---|---|---|
| I will bring expressed breast milk for my infant. | | |
| I want the child care provider to provide the infant formula it offers for my infant. | | |
| I will bring the infant formula for my infant.<br>Please list the kind of infant formula you will bring: | | |

**Preference regarding infant cereal and other foods**

| **Please mark your preference** | **Today's Date** ________ **6 – 11 months** |
|---|---|
| My child is developmentally ready for solid foods. I want the child care provider to provide the infant cereal and other foods for my infant. | |
| My child is developmentally ready for solids. I will bring the infant cereal and/or other foods for my infant. | |
| My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time. | |

Parent's (or guardian's) Signature__________________ Date of Signature__________

March 2021

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Part 1. All Household Members**

**Name of Enrolled Child(ren):**

| **Names of all household members** (First, Middle Initial, Last) | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM. | CHECK IF NO INCOME |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:________________________________________ ELIGIBILITY NUMBER: ________________________________________

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number: NAME: ________________________________________ ELIGIBILITY NUMBER: ________________

Check here if no eligibility number ☐

**Part 4. Total Household Gross Income—You must tell us how much and how often**

| **A. Name** (List **only** household members with income) | **B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1<br>1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
|---|---|---|---|---|
| *(Example) Jane Smith* | $200/weekly | $150/twice a month | $100/monthly | $200/bi-monthly |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: ________________________________________ Print name: ________________________________________

Date: ____________________________

Address: ________________________________________ Phone Number: ______________________

City:________________________________________ State: ________________ Zip Code: ________________

Last four digits of Social Security Number: _*_ _*_ _*_ - _*_ _*_ - __ __ __ __ ❑ I do not have a Social Security Number

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Part 6. Participant's ethnic and racial identities (optional)**

| Mark one ethnic identity: | Mark one or more racial identities: | |
|---|---|---|
| ☐ Hispanic or Latino | ☐ Asian | ☐ American Indian or Alaska Native |
| ☐ Not Hispanic or Latino | ☐ White | ☐ Native Hawaiian or Other Pacific Islander |
| | ☐ Black or African American | |

**Part 7. Sharing Information With Other Programs: OPTIONAL**

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

**Don't fill out this part. This is for official use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: ____________ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _________

Categorical Eligibility: ___ Date Withdrawn: ________ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: ______________________________________________________________

Determining Official's Signature: ________________________________________ Date: ______________

Confirming Official's Signature: ________________________________________ Date: ______________

Follow-up Official's Signature: ________________________________________ Date: ______________

**Privacy Act Statement:**

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.