

Welcome to Bright Beginners Preschool and Infant Care

Thank you for your interest in our program and for allowing our staff and church to assist you in the education and care of your child.

Attached you will find all the necessary forms for enrollment and information about our program. If you have any questions, please call on us to assist you at 281-469-2913.

Please carefully read all information included in this packet. Fill out and/or send the following items to Bright Beginners, unless noted otherwise:

1. Registration Forms
2. Statement of Health and Immunization Records:
This form is to be completed and signed by the child's physician or nurse and must be returned before the student can attend our program.
3. Medical Information Form
4. Bright Beginners 2025-2026 Class Schedule/Tuition Pricing:
Indicate your desired class on this sheet.
5. Parent Handbook Acknowledgement Form
6. Request for Keyless Code
7. Non-Refundable Registration and Activity Fee:
 - \$300 Registration Fee for 4 or 5 day enrollment
 - \$200 Registration Fee for 2 or 3 day enrollment
 - \$100 Registration Fee for Summer only enrollment

BRIGHT BEGINNERS PRESCHOOL AND INFANT CARE

A MINISTRY OF ST. TIMOTHY LUTHERAN CHURCH

14225 Hargrave Rd.

Houston, TX 77070

Phone: 281-469-2913

Office: Reg. Fee Paid _____

Start Date _____

REGISTRATION FORM

Please Print

CHILD'S FULL NAME _____ SEX _____

NAME CHILD IS CALLED (NICKNAME) _____ DATE OF BIRTH _____

ETHNIC ORIGIN _____ ASIAN _____ BLACK _____ HISPANIC _____ WHITE _____ OTHER _____

HOME ADDRESS _____ PHONE NUMBER _____ / _____

CITY _____ ZIP CODE _____ SUBDIVISION _____ SCHOOL DIST _____

MY CHILD IS BAPTIZED _____ YES _____ NO

FATHER'S NAME _____ OCCUPATION _____

E-MAIL ADDRESS _____

HOME ADDRESS IF DIFFERENT FROM ABOVE _____

PRESENT CHURCH MEMBERSHIP _____

MOTHER'S NAME _____ OCCUPATION _____

E-MAIL ADDRESS _____

HOME ADDRESS IF DIFFERENT FROM ABOVE _____

PRESENT CHURCH MEMBERSHIP _____

APPLICANT'S BROTHERS AND SISTERS NAME _____ AGE _____

NAME _____ AGE _____

EMERGENCY TELEPHONE INFORMATION

FATHER'S EMPLOYER _____

WORK _____ / _____ CELL PHONE _____ / _____

MOTHER'S EMPLOYER _____

WORK _____ / _____ CELL PHONE _____ / _____

**RELATIVES OR FRIENDS TO BE CONTACTED IN AN EMERGENCY
(IF PARENTS CANNOT BE REACHED)**

NAME _____ RELATIONSHIP _____ PHONE ____ / _____

ADDRESS _____

NAME _____ RELATIONSHIP _____ PHONE ____ / _____

ADDRESS _____

AUTHORIZATION TO ALLOW PERSONS OTHER THAN PARENT TO PICK UP CHILD

Please list persons approved to pick up your child other than yourself. Your child will not be released to others without your specific permission.

NAME _____ DRIVER'S LICENSE # _____ PHONE ____ / _____

NAME _____ DRIVER'S LICENSE # _____ PHONE ____ / _____

DATE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

I hereby give consent to Bright Beginners Preschool and Infant Care of Houston, Texas, to photograph, video tape, and tape record my child _____, during Preschool/Infant Care hours for use only relating to Preschool/Infant Care activities such as classroom projects, displays, etc.

DATE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

I hereby ☐ give ☐ do not give - consent for my child to participate in water table play and sprinkler play.

I understand that AM and PM Snack will be served to my child while in care. _____
Signature

How did you hear about Bright Beginners Preschool and Infant Care? _____

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14225 Hargrave Rd.

Houston, TX 77070

Phone: 281-469-2913

Immunization Record Attached_____

MEDICAL INFORMATION FORM

Child's Name _____ Birth Date _____ Phone _____

Parent's Name _____ Home Address _____

A child who appears ill upon arrival will not be admitted to class:

TEXAS DEPARTMENT OF PROTECTIVE & REGULATORY SERVICES (TDPRS)

REQUIRES THAT CHILDREN BE FREE OF FEVER, VOMITING, AND/OR DIARRHEA

FOR AT LEAST 24 HOURS BEFORE RETURNING TO SCHOOL. Our Center is not able to meet the needs of sick children.

Note: The parent should authorize the physician (at the time of registration) to accept a call from Bright Beginners Preschool and Infant Care for emergency medical care.

Authorization for Emergency Medical Care

Please accept this letter as authority to treat my child, _____, obtain emergency medical care and to be transported using emergency medical services in the event I cannot be reached at a time of illness or accident.

* Father's signature _____ Date _____

* Mother's signature _____ Date _____

(Both parents must sign unless the court has appointed custody to one parent.)

Name of parent's insurance company _____

Physician: Name _____

Address _____

Phone _____

Hospital: Name _____

Address _____

Phone _____

Health History: (Use another sheet if necessary)

Has this child:

- | | | |
|---|-----|----|
| • been toilet trained? | Yes | No |
| <hr/> | | |
| • existing illness(es)? | Yes | No |
| If yes, please name: _____ | | |
| <hr/> | | |
| • had previous injuries? | Yes | No |
| If yes, please describe: _____ | | |
| <hr/> | | |
| • had hospitalization during the past 12 months? | Yes | No |
| If yes, please describe: _____ | | |
| <hr/> | | |
| • any allergies? | Yes | No |
| If yes, please fill out the Allergy Action Plan | | |
| <i>Needs to be signed by a Physician <u>and</u> Parent</i> _____ | | |
| <hr/> | | |
| • Are there any parent concerns? | Yes | No |
| If yes, please describe: _____ | | |
| <hr/> | | |

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Admission requirements by the Texas Department of Protective and Regulatory Services:

There must be, on file within one week of admission, documentation of one or more of the following evidence that your child under 5 years old is able to take part in the program.

- _____ 1. A written statement from a licensed health professional who has examined the child within the past year;
- _____ 2. A signed statement from the parent:
- a. Giving the address of a licensed health professional; who has examined the child within the past year and stating that the child is able to participate in the program. This must be followed within 12 months by a document as described in 1 above;
OR
 - b. Giving the name and address of the licensed health professional; with whom an appointment for examination has been made. Following the examination, the parent must submit a document as described in 1;
OR
 - c. That medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization of which the parent is an adherent or a member.

Signature of parent or legal guardian

_____ Date _____

PLEASE ATTACH YOUR CHILD'S CURRENT IMMUNIZATION RECORD
BRIGHT BEGINNERS PRESCHOOL AND INFANT CARE
A MINISTRY OF ST. TIMOTHY LUTHERAN CHURCH
14225 Hargrave Rd.
Houston, TX 77070
Phone: 281-469-2913

STATEMENT OF HEALTH

Patient: _____ Date of Birth _____

Date of well check up: _____

Drug sensitivities/allergies: _____

**Vision Testing: _____

**Hearing Testing: _____

Comments: _____

I certify that the above named child is free of contagious or infectious disease, and I consider it safe for this child to attend a preschool program. He/She is current on all immunizations (copy attached) and may participate in all activities.

Physician Signature: _____ Date _____

Physician's stamp or address and phone:

****BY STATE LAW all children four years old by September 1** must have vision and hearing screening, the result of which must be reported to the state by the school. This screening may be done by the physician and recorded on this form or through the school at a cost of approximately \$15-\$20.