Early Enrollment

Preschool Year August 2019--May 2020

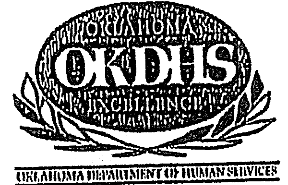
If you are planning to enroll your child for the next Preschool year, please, fill out and return the ***child Information and the OSIIS authorization form*** with the $40 enrollment fee to me before April 8, 2019. The tuition, hours and days of operation will remain the same.

In His Service,

Sherrill

Methodist Preschool

OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Child Information

Child's name			Sex	Date of birth
Name(s) of person(s) and the relationship with whom the child lives				
E-mail address			Area code	Home phone
Home street address	City		State	Zip
Mother/guardian's place of employment		Business, cellular, or page phone number		
Father/guardian's place of employment		Business, cellular, or page phone number		

Emergency contact

In case of emergency, if the parent or guardian cannot be reached, list person(s) to notify, in order of preference:

Immunization record

Attach a copy of the immunization record or follow the Oklahoma State Department of Health exemption procedures. Keep your child's immunizations current. Give updated immunization record copies to the child care facility.

A child two months of age or older cannot be admitted to a child care facility unless the parent presents certification from a licensed physician or authorized representative of any state or local Department of Health that such child has received or will receive immunizations at the medically appropriate time.

Health record

Child's physician or clinic			Phone
Street address	City	State	Zip

Does your child have any individual special needs involving routine care, behavior and guidance, communication, or positioning? If yes, please describe:

____

____

Is your child allergic to any foods, medications, etc.? If yes, please describe:

____

Describe any special precautions for diet, medication, or activity, if applicable:

____

____

I give permission to the child care staff to consult with health and child development professionals regarding my child's needs. Yes ☐ No ☐

Transportation

- I do not give permission for my child to be transported. ☐
- I give permission for this child to be transported: ☐
  - to nearest medical facility, if a medical emergency occurs and I cannot be reached ☐ ☐

Pick up permission

Persons having permission to pick up child:

Name	Phone

I understand this form is supplied by the Oklahoma Department of Human Services (OKDHS) as a service and that supplying the form in no way imposes any responsibility or obligation upon OKDHS.

The Parent's Guide to Selecting Quality Child Care, OKDHS publication number 87-91, and the *Child Care Facility Policies,* are available through your child's child care provider.

______________________________ ______________
Signature of parent/guardian Date

Date child entered facility: ______________ Date child withdrawn: ______________

Choose the days desired for **Preschool** Mon.___Tues._____Wed._____Thurs._____

Choose the days desired for **Extended Care.** Mon.___Tues._____Wed._____Thurs._____

T-shirt size 2T___3T___4T___5___6___7___

OSIIS - Authorization to Use or Share Protected Health Information to School or Day Care

Student Name: ______________________ Demographic/Client ID #: 4362
(For School/Day Care receiving PHI to fill out)

Date of Birth: ______________________

I hereby authorize the Oklahoma Immunization Service to release my Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to: Methodist Preschool /Sherrill.
(*Name of Person/Organization receiving PHI*)

The information may be disclosed for the following purpose(s):

☑ to ensure the student meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3

☐ Other: ______________________

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be **one year** from the date of my signature or upon the occurrence of the following event [*e.g.*, child no longer enrolled in school/day care center] the child is no longer enrolled.

______________________.

____
Signature of Student or Legal Representative

____
Date

____
Description of Legal Representative's Authority