

The School of Perpetual Motion
1452 E. Brown School Rd.
Maryville, TN. 37804
865-984-1253

Pre enrollment visit date _____ - _____ 20____ Parent/Guardian Signature _____

Date of Admission: _____ Today's Date: _____

Child's Full Name: _____ Birth date: _____

What my child likes to be called: _____

Child's Social Security number: _____

Parent's information:

Mother's Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Driver's License Number: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

Father's Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Driver's License Number: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

If emergency who do we contact first: _____

Whose custody is this child in: _____

Transportation Plans:

To ensure the safety of your child please list the adults that your child may be released to and have the authority to transport your child. Children shall not be released to anyone whose behavior may, as deemed by a reasonable person, place the child in imminent risk; provided, however, that if the staff of Perpetual Motion reasonably believes that refusal to release the child could place staff or other children in imminent risk Perpetual Motion may release the child, but must immediately call 911 or other local emergency services number.

We will not release a child to anyone we feel is under the influence of drugs or alcohol.

Please remind those who may pick up your child that they will have to show a photo ID.

Name: _____ *Relationship:* _____

Home Phone: _____ Cell Phone: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

Name: _____ *Relationship:* _____

Home Phone: _____ Cell Phone: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

Name: _____ *Relationship:* _____

Home Phone: _____ Cell Phone: _____

Employer name and address: _____

Work Phone: _____ Work Hours: _____

Emergency Information:

In case of emergency, we need a contact name. We will always call the parents or person who has custody of the child first. If we cannot contact that person, we need someone who is authorized to act for you in case of an emergency.

The following information needs to be someone other than parents.

Name: _____ *Relationship:* _____

Address: _____

Home Phone: _____ *Cell Phone:* _____

Employment: _____

Work Phone: _____ *Work Hours:* _____

If the center is unable to contact the parents, or emergency contact person we give the center and the staff of Perpetual Motion permission to treat my child.

Parents Name: _____

Signature of Parents: _____

Physician and Hospital information:

Physician Name: _____

Address: _____

City: _____ *Zip code:* _____

Office Number: _____

In case of emergency:

Hospital: _____

Address: _____

City: _____ *Zip code:* _____

Phone Number: _____

Background Information:

This Child lives with _____

If shared custody who is custody shared with and how is this arranged:

List everyone that lives in the home:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Is Perpetual Motion the first preschool or child care center the child will attend? Yes ___ No ___

If this is not the first preschool or child care center attended by your child, list historical information. The more recent centers should be listed first.

Preschool center name: _____ Enrolled ___/___/___ Withdrew ___/___/___

Preschool center name: _____ Enrolled ___/___/___ Withdrew ___/___/___

Preschool center name: _____ Enrolled ___/___/___ Withdrew ___/___/___

Authorized Release for Signing children in and out

It is required by DHS in **rule 1240-04-03-.05 (g)** that the custodial parent or other person specifically authorized by parent must sign their child in and out each day that they are present at Perpetual Motion. Failure to do so will cause us to have to call you to come back to the center to sign your child in.

Please sign below if you give Perpetual Motion staff permission to write your child in or out if for some reason you or any authorized person forgets to do so.

I _____, give Perpetual Motion staff permission to sign my child in or out of the center if for some reason I or other person specifically authorized by me forget to do so.

Experiences With Others

Please list any other play groups or child care situations your child has been in _____

What are some of the ways in which your child plays at home? _____

Does your child play with children from other families? Yes No
How? _____

Does your child usually get his/her way with other children: Yes No
Please explain how he/she reacts _____

Is the entire family together for any time during the day: Yes No

If yes, please explain _____

Eating Habits

At what time does your child eat breakfast? _____ Lunch? _____ Supper? _____

Between meal snacks? _____ Does he feed himself? _____

What is your child's general attitude toward eating? _____

If your child refuses to eat, how is it handled and by whom? _____

Favorite foods: _____

Disliked foods: _____

Please list all food allergies: _____

Sleep Habits

My child has his/her own room _____ Shares with siblings _____ Rooms with parents _____

At night sleeps from _____ to _____ Average hours _____

Naps from _____ to _____ Average hours _____

Attitude toward going to bed _____ If there is a difficulty, how is it handled? _____

Habits associated with going to bed _____

Does your child wet the bed? _____ At nap time? _____ At night? _____

If so, how is the problem handled? _____

Toilet Habits

Times at which your child is taken to the bathroom _____

Does your child take him/herself to the bathroom? _____ Times of bowel movements _____

Regular? _____ Constipated? _____ Does your child tell you when he/she needs to go to the toilet? _____

Does he/she go willingly? _____ Can your child manage their clothes at the toilet? _____

What words does he/she use for urinating? _____ BM? _____

Speech and Physical Growth

Does your child speak well? _____ Fairly well? _____ Not very well? _____ Not at all? _____

Does anyone read to your child? _____ How often? _____

At what age did your child creep? _____ Crawl? _____ Walk? _____

Would you describe your child as active or quiet; thin, average weight or heavy; tall, average height or short; friendly or unfriendly? Please comment: _____

Detail any other information you think we should know about your child: _____

I have received a copy of the parent handbook, along with a copy of the summary of the licensing requirements and community resource list. I do hereby authorize emergency medical care:

(Signature of Parent's)/Guardian

(Date)

Child's Health History Checklist

Child's Name

Birth Date

Parent(s) / Guardian Name

The answers to these questions will help us to better understand the medical history of your child. We need this information in case he/she should become ill and we were unable to reach you right away. Please circle the answer that applies.

- | | | |
|-----|----|---|
| Yes | No | 1. Has your child ever reacted to a DTP or other shots, or insects? |
| Yes | No | 2. Has your child had asthma or wheezing? |
| Yes | No | 3. Has your child had more than two ear infections in a year? |
| Yes | No | 4. Has your child had a bladder or kidney infection? |
| Yes | No | 5. Does he/she have burning when urinating? |
| Yes | No | 6. Does he/she have seizures, fits or shaking spells? |
| Yes | No | 7. Have you ever been told your child has a heart murmur? |
| Yes | No | 8. Is your child able to play as hard as other children? |
| Yes | No | 9. Has your child ever had a bumpy, swollen reaction to the TB skin test? |
| Yes | No | 10. Has your child ever been with anyone that has TB? |
| Yes | No | 11. Has your child ever had worms? |
| Yes | No | 12. Does your child scratch his/her genital area? |
| Yes | No | 13. Is his/her bottom or genital red or sore? |
| Yes | No | 14. Is your child on a heart monitor? |
| Yes | No | 15. Does your child have tubes in his/her ears? |
| Yes | No | 16. Does your child wear eyeglasses, contacts, hearing aids or dental appliances? |
| Yes | No | Can they be worn during gym class and outside play? |

Older Girls

- | | | |
|-----|----|---|
| | | 17. How old was your daughter when she had her first period? _____ or N/A |
| Yes | No | 18. Does your daughter have any problems with her period? |

General Development

- | | | |
|-----|----|---|
| Yes | No | 19. Is your child in a special needs class in school? |
| Yes | No | 20. Does your child have any physical or emotional limitations that would hinder their safety in the gym or outside playground? |

If yes, please explain in detail: _____

Additional Comments: _____

Preschool Children's Record Requirements:

Parents of children under the age of (30) months of age shall provide Perpetual Motion proof of a physical examination dated within (3) months prior to admission, signed or stamped by a physician or health care provider.

Perpetual Motion is required to have a updated copy of each preschool child's immunization record, signed or stamped by a certified health care provider, on file at the center. If this requirement is not met, your child may be disenrolled until the matter is taken care of.

Child's Health History Check List

Child's Name: _____ Date of Birth: _____

Parent(s)/Guardian's Names: _____

Medical History:

Please check all that apply

Measles	Mumps	Chicken Pox	Whooping Cough
Asthma	Tonsillitis	Ear Infections	Free Bleeder
Meningitis	Seizures	Reaction to TB Skin Test	

Allergies (Food, environmental, medication): _____

Does your child have any evidence of:

Hearing problems _____ Vision Difficulties _____ Speech Difficulties _____

Kidney Problems _____ Comments _____

List any:

Hospitalization _____

Serious Illnesses _____

Bone Fractures _____

Medications Taken on a Regular Basis _____

Does your child get along with other children: Yes No

Is he/she usually happy? Yes No

Does your child have any fears, phobias, physical restrictions
or problems not listed above? Yes No

If yes, please elaborate: _____

When did your child last see a doctor? ____/____/20__

MEDIA PERMISSION

Child(ren) _____

I give permission for the pictures/video of my child(ren) to be used or posted with the following:

Please Check All That Apply

_____ Web-Site – perpetualmotion4kids.com

_____ Facebook – perpetualmotion4kids@facebook.com

_____ Newspaper

_____ Television

_____ Classroom/Center

_____ First Names(s) may be used

I will receive no compensation or revenues of any kind. Perpetual Motion retains sole ownership of these digital photographs and videos and all rights associated with this material. All the above may be used in advertising or publicity and for other lawful purposes.

Specific use of notice: Photos and videos used for advertising within mass media such as newspaper and television, Perpetual Motion website and advertising flyers.

Parent /Guardian Printed Name _____

Parent/ Guardian Signature _____

Date _____

EXCLUSION SYMPTOMS

One of the best ways to prevent the spread of disease within your child care facility is to be aware of the warning signs of the presence of disease in children or caregivers. The American Academy of Pediatrics and the American Public Health Association recommend that any child who demonstrates the following signs, symptoms or diseases should be excluded from day care attendance, or should be sent home when they develop:

When these Signs, Symptoms or Diseases Appear	You Should Exclude Child Until
Fever >101° (Oral) or >102° (rectal) with behavior changes or other symptoms of illness	Doctor indicates that it is OK to return
Unusual lethargy, uncontrolled coughing, irritability, constant crying, difficult breathing, wheezing or other unusual signs	Doctor indicates that it is OK to return
Uncontrolled diarrhea – increased number of unusually loose stools	Until diarrhea stops
Vomiting – 2 or more times in 24 hours	Vomiting stops or Doctor indicates it is OK to return
Mouth sores with drooling	Doctor indicates it is non-infectious
Rash with fever or behavior changes	Doctor indicates it is non-infectious
Pink or red conjunctivitis ¹ with yellow or white eye discharge	24 hours after treatment is initiated
Scabies, head lice or other infestation	24 hours after treatment is initiated
Tuberculosis ²	Doctor indicates that it is OK to attend
Impetigo	24 hours after treatment is initiated
Strep throat or other streptococcal infection	24 hours after initial antibiotic treatment is initiated and no more fever
Chicken Pox	6 days after onset of rash or when all sores are dried over and crusted
Pertussis (whooping cough) ³	5 days after antibiotic treatments are started
Mumps ³	9 days after onset of gland swelling
Hepatitis A ^a	1 week after onset of illness or after health department has given immune serum globulin to all appropriate staff and children
Measles ³	6 days after onset of rash
Rubella ³	6 days after onset of rash
Shingles	All sores can be covered by clothing or when Doctor indicates it is OK to attend
Haemophilus influenzae ³ type b	The immunization status of other children and caregivers is known or when proper measures are initiated by the health department
Meningococcal infection	Appropriate measures are implemented by the local health department
Severe respiratory symptoms which limit the child's comfortable participation in activities or significantly increases the level of care necessary	Symptoms are resolved to the point where standard routines or activities will no longer be affected

Key

1-“Pink Eye” with clear or watery discharge is probably viral in nature and doesn't warrant exclusion

2- All staff should be screened for TB status prior to employment to minimize the possibility of spread within the center. Follow-up screening should be performed at least every 2 years.

3- These diseases can all be prevented with proper immunizations

a- Children with Hepatitis B need not be excluded unless they have behavioral risk factors (e.g. biting, frequent scratching) or generalized dermatitis or bleeding problems.

Note:

Children with HIV infection should be admitted to child care as long as their health, neurological development, behavior or immune status don't compromise their own health or that of others. This determination should be made on a case by case basis by qualified individuals, including the child's health-care provider.