

**2010-2011  
ENROLLMENT AGREEMENT  
THE HEIGHTS BAPTIST CHURCH  
CHILD DEVELOPMENT CENTER  
201 W. RENNER ROAD  
RICHARDSON, TX 75080  
(972) 238-7289 [www.cdctheheights.org](http://www.cdctheheights.org)  
Director: Marie Ruiz**

**OFFICE USE ONLY:**

Adm. Date: \_\_\_\_\_  
Reg. \_\_\_\_\_  
Check No. \_\_\_\_\_  
Class: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
Withdrawal Date: \_\_\_\_\_  
Conf. Pack sent?: \_\_\_\_\_

\_\_\_\_\_ BOY  
\_\_\_\_\_ GIRL

CHILD'S NAME \_\_\_\_\_  
(Last) (First) (Middle) (Name Called)

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Month/Day/Year)

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Business Telephone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Business Telephone \_\_\_\_\_

E-Mail \_\_\_\_\_ I would like to be included in a weekly e-mail

Name & Age of Siblings \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Church Attending \_\_\_\_\_

Please list names, addresses & telephone numbers of any person to whom your child may be released and persons to contact when you cannot be reached.

Name	Address	Phone	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Authorization For Emergency Medical Attention:** In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

**Name of Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_  
\*

**Name of Emergency Medical Care Facility:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_  
\*

I give consent for the facility to secure any and all necessary emergency medical care for my child.

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*

**If no Emergency Medical Care Facility is listed, your child will be taken to Richardson Regional Medical Center, located at 401 W. Campbell Rd. Richardson, TX 75080 972-498-4000**

**PERSONAL HISTORY**

- 1) Does child live with both parents? \_\_\_\_\_, Mother \_\_\_\_\_, Father \_\_\_\_\_  
Other? \_\_\_\_\_
- 2) The primary language spoken at home is \_\_\_\_\_
- 3) Has your child had a previous group or preschool experience? \_\_\_\_\_ Where \_\_\_\_\_
- 4) What words does your child use for toileting? \_\_\_\_\_  
**(The \*Handbook states that all 3 year olds MUST be toilet trained.)** (\*Children should be able to tell the teachers, go to the restroom and care for their restroom needs by themselves.)
- 5) Does your child have any of the following: (If yes, please explain)  
**Allergies?** \_\_\_\_\_  
Previous serious illness or injuries? \_\_\_\_\_  
Hospitalization during the last 12 months? \_\_\_\_\_  
Any medication prescribed for long-term use? \_\_\_\_\_
- 6) Are there any other problems regarding your child's health and/or behavior which you feel we should be aware of? \_\_\_\_\_

**REGISTRATION FEE/SUPPLY FEE – NON-REFUNDABLE**

\*Discount on registration fee/supply fee of 25% for more than one child. The lowest fee will be discounted.

<b>NUMBER OF DAYS</b>	<b>DAYS OFFERED</b>	<b>REGISTRATION FEE</b>	<b>TUITION (September-May)</b>	<b>PLEASE CHECK</b>
<b>ONE DAY</b> <b>3 month olds to Transitional 3 year olds.</b>	Tuesday Wednesday Thursday Friday	\$135.00	\$135.00	Tuesday____ Wednesday____ Thursday____ Friday____
<b>TWO DAYS</b> <b>All ages</b>	T/TR W/F	\$145.00	\$210.00	T/TR____ W/F____
<b>THREE DAYS</b> <b>All ages</b>	T/W/TR	\$165.00	\$280.00	T/W/TR____
<b>FOUR DAYS</b> <b>All ages</b>	T-F	\$210.00	\$365.00	T-F____
<b>TRANSITIONAL KINDERGARTEN</b> <b>Turning 5 in Spring 2010-Fall 2010</b>	T-F	\$250.00	\$395.00	T-F____

**By signing this document I agree & understand that at no time or for any reason is the Registration/Supply fee refundable.**

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Staff's Signature \_\_\_\_\_ Date \_\_\_\_\_