Enrollment Forms
2024-2025

Casa de Colores

Montessori School

Address: 4539 Emory Rd. El Paso TX, 79912
Phone number: (915)300-2100
Director: Julie Armendariz

Building fee $150 per semester (this applies to all students).
Nidos 0-17 mo.
Registration $495.00
1/2 day program 8:30-11:30
$9,150.00
Full day program 8:30-2:30
$12,040.00

Infant Community 18mo.-3 yrs.
Registration $495.00
1/2 day program 8:30-11:30
$7,320.00
Full day program 8:30-2:30
$9,020.00

Children House 3-6 yrs.
Registration $495.00
1/2 day program 8:30-11:30
Tuition $7,550.00
Full day program 8:30-2:30
$8,700.00

Lower Elementary 6-9yrs.
Registration $495.00
8:30-2:30
Tuition
$9,020.00

Upper Elementary 9-12
Registration $495.00
8:30-2:30
$9,315.00

An Evaluation is required for all children on the spectrum. This May or May not reflect your tuition.

Updating Records

_____ Updated Admission Form

_____ Copy of Immunization Record

_____ Physician Health Statement

_____ Brachiation Ladder Form

_____ Children's Risk Assessment Form

_____ Discipline and Guidance Form

_____ Vision & Hearing

_____ Parent Signature of Handbook / Participation

_____ ~~Parent Participation Signature~~ Emergency form

_____ Media Release

_____ Back Ground Check

_____ Registration

_____ Building Fee ($200)

_____ Complete set of extra clothing

Please return paper work that is marked_____

TEXAS
Health and Human Services

Form 2935
April 2018-E

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name	Director's Name

Child's Full Name	Child's Date of Birth	Child Lives With
		◯ Both parents ◯ Mom ◯ Dad ◯ Guardian

Child's Home Address	Date of Admission	Date of Withdrawal

Name of Parent or Guardian Completing Form	Address of Parent or Guardian (if different from the child's)

List telephone numbers below where parents/guardian may be reached while child is in care.

Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File
			◯ Yes ◯ No

Give the name, address, and phone number of the responsible individual to **call in case of an emergency** if parents/ guardian cannot be reached	Relationship

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

Name	Phone Number
Name	Phone Number
Name	Phone Number

Consent Information

Check All That Apply:

1. Transportation

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips

◯ I give consent for my child to participate in field trips.

◯ I do not give consent for my child to participate in field trips.

Comments

3. Water Activities

I give consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals

I understand that the following meals will be served to my child while in care:

☐ None ☐ Breakfast ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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 Number
Name of Emergency Care Facility	Address	Phone Number
I give consent for the facility to secure any and all necessary emergency medical care for my child.	_____ Signature — Parent or Legal Guardian	

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? ◯Yes ◯No

Plan Submitted on

Child day 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).

Signature — Parent or Legal Guardian

Date Signed

School Age Children

My child attends the following school	School Phone Number

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Check **only one** option:

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

Signature — Parent or Legal Guardian

Date Signed

2. ◯ A signed and dated copy of a health care professional's statement is attached.
3. ◯ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated 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 day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name	Address of Health Care Professional

Signature — Parent or Legal Guardian

Date Signed

Requirements for Exclusion

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature Date Signed

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature _____ Date Signed _____

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine.

Signature _____ Date Signed _____

Additional Information Regarding Immunizations

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

TB Test (If Required)

◯Positive ◯Negative Date _____

Gang Free Zone

Under the Texas Penal 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 penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian	Date Signed
Center Designee	Date Signed

MEDICAL STATEMENT TO BE COMPLETED BY PHYSICIAN

Date of Examination:_____

_____has been examined by me and found free of

Childe's Name

Infectious and contagious disease and is physically and mentally able to participate in group activities.

Any allergies or special recommendations:

_____

_____

_____ _____ _____

PHYSICIAN'S SIGNATURE ADDRESS TELEPHONE

Brachiation Ladder Form

Date _____

Brachiation Ladder is used for the overall health, fitness, and physical development of children. Skills developed from brachiation include building strength, endurance, and flexibility, as well as eye-hand coordination, visual distance perception, and balanced locomotor patterens.

Babies naturally grip with their hands and most children develop sufficient grip and upper body strength to support their body weight by the age of two. This stage needs full adult assistance to reach the first rung and to traverse to the next one. An adult will need to assist to all children until the age of 5.

This ladder can also be used for the treatment of children with cerebral palsy, autism, and brain injuries to expand their physical development, which stimulates brain development and their learning capabilities.

(Child's Name)_____ D.O.B._____

Has been approved by a medical physician to participate on the Brachiation Ladder.

Physician Signature _____

Address_____ Telephone _____

TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries? _____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ___/___) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ___/___) No___

For school/healthcare provider use only

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PPD administered Yes___ No___

If yes,

Date administered ____/____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____

signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

TEXAS Department of State Health Services

TEXAS Health and Human Services

Form 1099
July 2019-E

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

Discipline must be:

1) Individualized and consistent for each child;
2) Appropriate to the child's level of understanding; and
3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
2) Reminding a child of behavior expectations daily by using clear, positive statements;
3) Redirecting behavior using positive statements; and
4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

1) Corporal punishment or threats of corporal punishment;
2) Punishment associated with food, naps, or toilet training;
3) Pinching, shaking, or biting a child;
4) Hitting a child with a hand or instrument;
5) Putting anything in or on a child's mouth;
6) Humiliating, ridiculing, rejecting, or yelling at a child;
7) Subjecting a child to harsh, abusive, or profane language;
8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: ◯ Parent ◯ Caregiver/Employee ◯ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y
- Title 26, Chapter 747 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y
- Title 26, Chapter 744 Subchapter G: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y

I have read the parent handbook in full and agree to the terms and conditions listed.

My child is enrolled ___ part-time ____ full time and I agree to the tuition and year registration fees.

I also agree to the parent volunteer commitment listed in the handbook.

Student Name _____

Parent Name_____

Signature _____Date _____

Received by _____ Date_____

Release Form for Media Recording

I, the undersigned, do herby consent and agree that *Casa de Colores Montessori*, its employees, or agents, have the right to take photographs, videotape, or digital recording of my child _____. These can be used in any and all media, now or hereafter known, and exclusively for the purpose of promotion, interest stories, and newsletters. I further consent that my child's name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release *Casa de Colores Montessori*, and its agents, and employees all rights to exhibit this work in print and electronic form publicity or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.
I also understand that *Casa de Colores Montessori* is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Child's Name:_____

Name:_____

Date:_____

Address:_____

Phone:_____

Witness for the undersigned:_____

Signature:_____

Emergency form

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for:

Si en caso de alguna enfermedad o accidente no me pueden localizar para arreglar atención médica de emergencia para mi niño, doy permiso para que:

Name of Day Care Facility Owner or Director
Nombre del Dueño o Director del Centro de Cuidado de Niños
Julie Smith - Director of Casa De Colores Montessori School
[redacted] - Administrator, Casa De Colores Montessori School

to take my child (or children):

a que lleve a mi niño (o mis niños):

Name of Child (1)/Nombre del Niño (1)	**Name of Child (2)**/Nombre del Niño (2)
Name of Child (3)/Nombre del Niño (3)	**Name of Child (4)**/Nombre del Niño (4)

to: a:

Name of Doctor/Nombre del Doctor	**Telephone No.**/Teléfono
Address of Doctor/Dirección del Doctor	

or to: o a:

Name of Hospital or Clinic/Nombre del Hospital o Clínica	**Telephone No.**/Teléfono
Address of Hospital or Clinic/Dirección del Hospital o Clínica	

I give consent for necessary emergency treatment when my child is in the care of this physician or hospital or clinic.

Doy mi consentimiento para el tratamiento médico necesario estando mi niño bajo la atención de este doctor u hospital o clínica.

_____ _____

Signature-Parent or Legal Guardian
Firma-Padre o Tutor

Date/Fecha