Received By: ____________

Date/Time: ____________

Payment:

(Form/ Amount): ________

(Office Use Only)

4545 Wildcat Drive
Portland, Texas

New Family Registration Summary 2024/2025 School Year

Tuesday, April 2, 2024 @ 8AM

Child's Name ______________________________ **Date of Birth:** __________________________

#Months old as of 9/1/2024: _______________

Parent's Name: ____________________________ Phone #: ______________________________

Email: ________________________________

Schedule Preference: (Select 1st, 2nd)

Toddler Options:

18 MO - Pink MWF $425/MO __________ (18-35 mo)

18 MO – Pink Tues/Thurs. $315/MO_________ (18-35 mo)

PreK 2-Year-Old Options:

2yr – Red Monday-Friday $515/MO _________ (24-35 mo)

2.5yr – Orange Tues/Thurs. $315/MO _________ (30-35 mo)

PreK 3-Year-Old Options:

3yr – Yellow Monday-Friday $485/MO _________

3yr – Orange MWF $370/MO __________

3yr – Green Tues/Thurs. $315/MO _________

==

Flex PK3/4 Year-Old & PK4 Year-Old Options:

3/4yr Purple (44-48+mo) Monday-Friday $485/MO ________

4yr Blue (48mo+) Monday-Friday $485/MO ________

4yr Green (48mo+) MWF $ 370/MO ____________

==

(See Pg 2 on Back)

- If placed in a class today, be prepared to pay $150 Non-Refundable Registration Fee
- If placed in a class today, be prepared to pay $125 Curriculum / Supply Fee (Split Option $150)
- Return Application & Current Immunizations by: **April 9, 2024**

Please Initial:

_____ I am _______ or I am not______ an ACTIVE FUMC Portland Church Member

_____I have received & signed "Toileting Policy" (3YO Classes)

_____ I have received "Link to Family Handbook" www.fumcportlandtx.org/mds

_____ I have completed – Automated Processing Authorization (ACH)

_____ I have paid a total $_____________ for the Registration Fee & Curriculum/Supply Fee (All Non-Refundable)

Form of Payment: ________ ACH _______ Check ______ Money Order

Payment Arrangements if applicable: ___________________________________

Notes/Comments:

____

____

____

Dear Parent(s),

Can you believe plans for the **2024-2025** school year are already underway? To streamline the Pre-Registration process, we are requiring certain information in advance to solidify your enrollment slot for next year. The information is as follows:

☑	Childs Name: ______________	Parent's Name: ______________
	2024-2025 Admissions Form	• The whole document must be completed, including the full Address & Phone number for Emergency Contact/Pick Up, Doctors and Hospital • If your child has already turned 4 years old, the doctor can fill out the Hearing & Vision results from the child's 4-year-old physical. Pre-schedule Dr. appointments if applicable
	Health Statement	• The doctor can sign this form; it can be the child's latest physical; or a doctor's note stating the child is clear to participate in school. ***If your child has a birthday from March-August, get the copy when the child goes to the doctor. Please do not make an extra doctor appointment for this***
	Family Survey	• Please fill this out completely; it gives the Teachers valuable information about your child and family
	Immunizations – Updated	• If your child has had immunizations since school started this year, bring an updated copy. ***If your child has a birthday from March-August, get the copy when the child goes to the doctor. Please do not make an extra doctor appointment for this***
	Registration Fee (Non-Refundable)	• The Registration fee is $150.00 Any siblings have a discounted rate of $130.00. ○ For example, a brother and sister would cost $280.00; $150.00 for the first child and $130.00 for the second child
	Curriculum/Supply Fee (Non-Refundable)	• $125 due with registration or $150 if split ½ at registration and ½ by 12/1/2024
	Automatic Bank Draft	• Automatic bank draft is the method of payment for tuition/fees. Draft options: 5th or split on the 5th and 15th

Your enrollment slot will only be held when ALL these items are completed, submitted and all fees paid. * See deadline for forms

Please share this information with your friends and family. We appreciate your referrals. All information about Methodist Day School including family handbook, tuition, fees, staff, Facebook link, and calendar can be found on our website at www.fumcportlandtx.org/mds

Thank you,

Angela McDaniel, Director

Suzanne Gardner, Asst. Director

Methodist Day School Tuition 2024-2025

Classes	Rates
Toddler	
Tuesday/Thursday 18mo-35mo	$315
MWF 18mo – 35mo	$425
PreK 2-Year-Old	
M-F PK2	$515
T/TH PK2.5	$315
PreK 3-Year-Old	
M-F PK3	$485
MWF PK3	$370
T/TH PK3	$315
Flex PreK 3&4 -Year-Old **PK 4 Year Old**	
M-F PK 3-4 (Purple) 44-48mo+	$485
M-F PK 4 (Blue) 48mo +	$485
MWF PK4 (Green) 48mo+	$370
• Registration Fee	$150
• Curriculum/Supply Fee	$125 ($150 split option)
• Standard Operating Hours	8:30 AM – 2:30 PM
Extended Hours	7:15 AM – 4:15 PM
• Flat Rate Before/After Care	$185/mo
• Morning Care - 7:15-8:30 AM	$5 Day
• After Care – 2:30 – 4:15 PM	$8 Day

METHODIST DAY SCHOOL | ADMISSION INFORMATION 2024-2025

Operation: Methodist Day School	Director: Angela McDaniel	Date of Admission:	Date of Withdrawal:
Child's Full Name:		Child's Date of Birth:	Child's Age on Sept. 1, 2024:
Child's Home Address:		City:	Zip Code:
Mother/Guardian's Name:		Address (if different)	Email:
Mother/Guardian's Phone Number & Carrier (AT&T, etc.):		Occupation:	Work Number:
Father/Guardian's Name:		Address (if different)	Email:
Father/Guardian's Phone Number & Carrier (AT&T, etc.):		Occupation:	Work Number:
Religious Affiliation:	Name of Church you attend:		Are you actively involved?

Give the Name, Address and Phone Number of the person(s) to call in case of an Emergency if you the Parent/Guardian cannot be reached and CHECK OFF if they are an Emergency Contact and/or a person authorized to pick the child up from the childcare operation. Children will only be released to a parent or person designated by the parent/guardian after verification of I.D. (18yr +).

Name:	Relationship:	Address, including City & Zip Code:	Phone Number:	ER Contact:	Pick Up:
				☐	☐
				☐	☐
				☐	☐

CHECK ALL THAT APPLY:

1. **TRANSPORTATION:**	I hereby ☐ give ☐ do not give	- consent for my child to be transported and supervised by MDS employees and/or parents: ☐ for Emergency Care ☐ on Field Trips
2. **FIELD TRIPS (PreK4 only):**	I hereby ☐ give ☐ do not give	- consent for my child to participate in Field Trips. **Parent's Comments:**
3. **WATER ACTIVITIES:**	I hereby ☐ give ☐ do not give	- consent for my child to participate in Water Activities: ☐ Water Table Play ☐ Sprinkler Play ☐ Splashing/Wading Pools
4. **RELEASE TO BE PHOTOGRAPHED/VIDEO:**	I hereby ☐ give ☐ do not give	

5. **RECIEPT OF WRITTEN OPERATIONAL POLICIES (See Family Handbook @ www.fumcportlandtx.org/mds)**

☐ I acknowledge receipt of the Family Handbook which includes the operational policies, including discipline and guidance.
☐ I acknowledge the MDS Policy that my child must be potty trained before entering the 3 and/or 4-year-old classroom.
☐ I acknowledge childcare operations are public accommodations under ADA, Title III. If you believe an operation may be practicing discrimination in violation of Title III, you may call the ADA line at (800) 514-0301 (voice) or (800) 514-0383 (TTY)
☐ I acknowledge any area within 1,000 ft. of MDS is a Gang-Free Zone under Texas Penal Code. Criminal offenses related to organized criminal activity are subject to harsher penalties.

6. **I UNDERSTAND THE FOLLOWING: MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE & MDS IS NOT RESPONSIBLE FOR ITS NUTRITIONAL VALUE OR FOR MEETING MY CHILD'S DAILY FOOD NEEDS:**

☐ AM Snack (Parent's provide) ☐ Lunch (Parent's provide) ☐ PM Snack in Aftercare (MDS provides)

7. **MY CHILD IS NORMALLY IN CARE ON THE FOLLOWLING DAYS AND TIMES: - (See Tuition Schedule)**

☐ Tuesday/Thursday from 8:30 AM. to 2:30 PM $ ___________
☐ Monday/Wednesday/Friday from 8:30 AM to 2:30 PM $__________
☐ Monday – Friday from 8:30 AM to 2:30 PM $ ___________
☐ *I understand there is a $150.00 Non-Refundable Registration Fee & $125 Non-Refundable Curriculum/Supply Fee (Split Option available)*

EXTENDED CARE:
☐ 7:15-8:30am: $5.00 daily
☐ 2:30-4:15pm: $8.00 daily
** Flat Rate Option $185/mo
Extended Care is only for children 2 years of age and older

AUTO DRAFT:
☐ 5TH of the month
☐ 5th & 15th of the month

METHODIST DAY SCHOOL | **ADMISSION INFORMATION 2024-2025**

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: (Must be filled out completely)
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, including City & Zip Code:	Phone Number:
Name of Emergency Medical Care Facility:	Address, including City & Zip Code:	Phone Number:

RELEASE OF LIABILITY:
I agree that Methodist Day School, its Board of Directors and First United Methodist Church will not be held responsible in case of sickness or injury to my child while in attendance and/or participation in an MDS activity.

I give consent for the facility to secure any and all necessary emergency medical care for my child. Furthermore, I understand any expenses incurred (which are not covered by First United Methodist Church's liability insurance) will be my responsibility.

____
Parent/Guardian Initials

SPECIAL NEEDS / ALLERGIES / MEDICATION

- List any Special Needs your child may have, such as environmental and/or food allergies, developmental diagnosis, existing illnesses, previous serious illnesses, injuries and hospitalizations during the past 12 months.
- Please list any medication prescribed for long-term, continuous use & any other information which caregiver's should be aware of.

☐ N/A

IMMUNIZATION RECORD: ***Please check only ONE option***

☐ I have provided the childcare operation with a copy of my child's most current Immunization Record.

☐ I have attached a signed & dated Affidavit stating that I decline Immunizations for reasons of conscience, including religious belief, on the form described by Section 161.0041 Health & Safety Code submitted no later than the 90th day after the affidavit is notarized. I understand the Affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm
HHSC values your privacy. For more information, read our Privacy & Security Policy online at https://hhs.texas.gov/policies-practices-privacy#security

ADMISSION REQUIREMENT: ***Please check only ONE option***

☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in the childcare program.

Name of Physician:	Address, including City & Zip Code:	Phone Number:

______________________ ______________________
Health Care Professional's Signature Date

☐ A signed and dated copy of a Heath Care Professional's statement (Physical form) is attached.

☐ 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.

☐ My child has been examined within the past year by a Health Care Professional and is able to participate in the child care program. Within 12 months of admission, I will obtain a Health Care Professional's signed statement and will submit it to the child care operation.

4-5 year olds ONLY

VISION SCREENING	Right Eye 20/ ______	Left Eye 20/ ______	☐ PASS ☐ FAIL

______________________ ______________________
Health Care Professional Signature Date

HEARING SCREENING	1000 Hz	2000 Hz	4000 Hz	Results
Right				☐ PASS ☐ FAIL
Left				☐ PASS ☐ FAIL

______________________ ______________________
Health Care Professional Signature Date

______________________ ______________________
Parent/Guardian's Signature Date

______________________ ______________________
Staff Signature Date

Family Survey

Child's Name: ______________________ **Parent's Name:** ______________________

1. What language does your family primarily speak at home?

   ____

   ____

2. What best describes your child's ethnicity? ☐ Hispanic ☐ Non-Hispanic

3. What best describes your child race?

   ☐ White
   ☐ Asian
   ☐ Native Hawaiian
   ☐ Black/ African American
   ☐ Native American/ Indian
   ☐ Other: ______________________

4. Is your child potty trained?

   ☐ My child is in Diapers

   ☐ My child is in Pull Ups and/or in the process of Potty Training

   ☐ My child is Potty Trained (required for the 3 & 4 year old classes)

5. How did you hear about us?

   ☐ Friend / Word of Mouth Referral
   ☐ Facebook / Social Media
   ☐ FUMC Portland Digital Sign
   ☐ FUMC Portland Website
   ☐ Advertisement
   ☐ Newspaper

6. What Parent Volunteer opportunities are you interested in (Examples are in the Family Handbook)?

   ☐ Room Parent
   ☐ Teacher Luncheon Committee
   ☐ Fall Festival Committee
   ☐ (e)Mpower Group
   ☐ Book-a-Palooza Committee
   ☐ Western Days Committee
   ☐ Week of the Young Child Committee
   ☐ Fundraising Committee

7. Are you actively involved in a church? ☐ Yes ☐ No
   a. If so, what denomination? b. Name of Church ______________________

   ☐ Methodist
   ☐ Non-Denominational
   ☐ Baptist
   ☐ Presbyterian
   ☐ Muslim
   ☐ Lutheran
   ☐ Jesus Christ of Latter Day Saints
   ☐ Hindu
   ☐ Church of Christ
   ☐ Catholic
   ☐ Episcopalian
   ☐ Jewish
   ☐ Pentecostal
   ☐ Buddhist
   ☐ Seventh Day Adventist
   ☐ None
   ☐ Other: ______________________

   ____

8. Tell me about things your child likes/ interests they have

9. Tell me about things your child dislikes

10. Does your child have any fears (thunder, bugs, animals, etc.)

11. Tell us about any developmental/ learning concerns you or your doctor may have, if applicable

12. Tell us about other people in your household (siblings, other family members, etc.)

13. Tell us about any pets you have

14. What are your child's favorite snacks/ foods?

15. Is there anything else you would like to share with us about your child or family?

16. Does your child have any special needs and or allergies we should be aware of? Do we have an action plan and/or required medication registered with the office?

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We are excited to offer the safety, convenience, and ease of Tuition Express® a payment processing system that allows secure, on-time tuition and fee payments to be made from your bank account.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I (we) hereby authorize Methodist Day School to initiate debit entries to my (our) checking or savings account indicated below. To properly affect the cancellation of this agreement, I (we) am required to give 10 days' written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments.

In addition to monthly recurring drafts, I (we) hereby authorize Methodist Day School to initiate a debit to my (our) checking or savings account indicated below in the amount of $__________ on _______________ for the Non-Refundable Registration/Curriculum Supply Fee required to secure my enrollment for the 2024/2025 School Year.

Special Notes: ____

BANK AUTO DRAFT INFORMATION

Your Name Phone #

Address City State Zip

Bank or Credit Union Name Bank or Credit Union Address City State Zip

Routing Transit Number Account Number ☐ Checking ☐ Savings

Authorized Signature Date

Options for Auto Draft: (Please Check One)

☐ 5th of the Month ☐ Split 5th & 15th

A Service of

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: ____________

Allergic to: ______________________

Weight: __________ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Methodist Day School

4545 Wildcat Drive

Portland, Texas 78374

Individualized Emergency Plan

Child's Name: ______________________________ D.O.B.: ______________

Parent's Name: ______________________________ Phone: ______________

Doctor's Name: ______________________________ Phone: ______________

To be filled out completely by the child's doctor:

List Food Allergies or Health Condition(s):
List Medications/ Equipment needed onsite:
Explain symptoms or health concerns to watch for and when to call Parent(s):
Call 911 when the following symptoms occur:

Doctor's Signature: ______________________________ Date: ______________

Parent's Signature: ______________________________ Date: ______________