

Early Childhood Laboratory School
A Reach Toward Excellence

Delaware State University

Department of Human Ecology
Education & Humanities Building
Dover, Delaware 19901
302.857.6731

Enrollment Packet

Child's First Name: _____ Last Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ years _____ months Sex: _____

Home Address: _____

Home Telephone Number: _____

Primary language spoken in the home:

Father's Name: _____ Does child live with natural father? _____

Place of Employment: _____ Work Phone: _____

Mother's Name: _____ Does child live with natural mother? _____

Place of Employment: _____ Work Phone: _____

Siblings Name: _____ Age: _____ Sex: _____ Grade: _____ School: _____

Siblings Name: _____ Age: _____ Sex: _____ Grade: _____ School: _____

Siblings Name: _____ Age: _____ Sex: _____ Grade: _____ School: _____

Siblings Name: _____ Age: _____ Sex: _____ Grade: _____ School: _____

Other Household Members: Name and Relationship: _____

Name and Relationship: _____

Type of Housing: (Apartment, House, Other) _____

DEVELOPMENT

Your answers to these questions can help us to understand your child. They also let us know what concerns you may have about your child.

Please describe your child:
What is your child doing? (Developmentally)
What are your child's strengths?
Does your child have any needs that require special accommodations?
What questions or concerns do you have about your child?
What are your child's favorite activities?

The following statements describe possible problems that your child may have. Read each statement carefully and mark (x) those statements that describe your child.

<input type="checkbox"/> Health Problems	<input type="checkbox"/> Dependent and clingy
<input type="checkbox"/> Growth, height, or weight problems	<input type="checkbox"/> Passive; seldom shows initiative
<input type="checkbox"/> Eating problems (eats poorly or too much)	<input type="checkbox"/> Disobedient
<input type="checkbox"/> Bowel and bladder problems	<input type="checkbox"/> Temper Tantrums
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Overly Aggressive
<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Can't sit still
<input type="checkbox"/> Tired and sluggish	<input type="checkbox"/> Timid, fearful or worries a lot
<input type="checkbox"/> Seems to have trouble seeing	<input type="checkbox"/> Often seems unhappy
<input type="checkbox"/> Seems to have trouble hearing	<input type="checkbox"/> Seldom plays with other children
<input type="checkbox"/> Does not pay attention	<input type="checkbox"/> Immature, acts much younger than age
<input type="checkbox"/> Does not talk well for age	<input type="checkbox"/> Clumsy
<input type="checkbox"/> Speech is difficult to understand	<input type="checkbox"/> Does not seem to understand well

Source: Child Development Review 1990, Harold R. Ireton, PhD.

HEALTH INFORMATION

Name of Physician: _____ Telephone Number: _____

List Medical or Food Allergies/Exemptions: _____

List Continuous Medications: _____

PERMISSION FORM

I hereby give permission for _____ to participate
in the following activities at the Delaware State University Lab School:

_____ I understand that I will be notified prior to a scheduled field trip or excursion and will be given information regarding transportation, destination, meals, arrival and departure times.

_____ Pictures and videos taken of my child will be used for educational purposes, teacher training or decoration in the Lab School.

_____ Students in training programs at the University will interact with my child for educational purposes, lab and practicum assignments.

_____ Emergency Medical Care by BayHealth (Kent General Hospital)

Signature of Parent/Guardian: _____ Date: _____

EMERGENCY INFORMATION

*For Classroom Use. Must be updated regularly.

Name of Child: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

Father's Daytime Contact Information: _____

Mother's Daytime Contact Information: _____

Persons Authorized to pick up your child:

Name: _____	Telephone Number: _____
Name: _____	Telephone Number: _____
Name: _____	Telephone Number: _____
Name: _____	Telephone Number: _____
Name: _____	Telephone Number: _____

***** Under no circumstances will a child be released to anyone without proper photo identification matching the above name or anyone under the age of 18 years. It is legal for either natural parent to pick up their child unless we have a copy of a court order restricting visitation of a parent.

In the case of an emergency when we cannot contact either parent/guardian, list an alternative adult(s) who will take responsibility for your child.

Name: _____ Relationship to child: _____

Address: _____ Telephone Number: _____

Name: _____ Relationship to child: _____

Address: _____ Telephone Number: _____

TUITION AND PAYMENT AGREEMENT

I agree to pay an annual registration fee of **\$50.00** to enroll my child in the Early Childhood Laboratory School at Delaware State University. The tuition for attendance in the Lab School is **based on household income** for 10 months of service, September through June. Payment can be made by money order, cash or check in the Administration Building 1st floor Cashier's Office or credit card online through NelNet QuikPay. The University accepts self-arranged purchase of care through the Division of Social Services- Delaware Health and Social Services. Parents/guardians are responsible for paying the University for services rendered and completing and returning all documentation before receiving a reimbursement from DSS. There is a \$50 monthly discount for additional siblings enrolled in the Lab School. A late fee of \$35.00 will be assessed if a tuition payment is not received by the 15th of the month. Your child will not be permitted to return to school without a receipt of payment on the following Monday.

Please select your preferred type of payment plan below.

Partial payment. 1/2 monthly tuition is due by 2nd Friday, remainder due my last Friday. No late fees will be incurred.

Full payment. Due by 1st Friday. Late fees incurred on following Monday

In the unfortunate event that you choose to withdraw your child, you must provide 2-week notice. If your CDL account has an outstanding balance, the account will go to collections after 30 days.

Parent/Guardian Signature _____ Date _____

Director's Signature _____ Date _____

BUSINESS OFFICE FORM

Dear Parents/Guardians,

Please include the non-refundable registration fee of \$50.00 and return this form to the Cashier's window in the Administration building to set up your CDL account. (9:00 am-4:00 pm M-F)

Child's Name _____

Social Security Number _____

Parent or Guardian's Name _____

Social Security Number _____ Date of Birth _____

Street Address _____

City, State and Zip Code _____

Home Phone Number _____

Alternate Phone Number _____

Email Address _____