



# CHINMAYA EARLY EDUCATION PROGRAM

## Registration Form for 2018-2019

Date of Enrollment: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Sex: M\_\_ F\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_

Marital Status: Married / Widowed / Divorced / Single / Other

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Place of work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_

Marital Status: Married / Widowed / Divorced / Single / Other

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Place of work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

ID#: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_ Phone#: \_\_\_\_\_

Person(s) to contact in case of emergency/Authorized to pick up child:

1.Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2.Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other Person(s) Authorized to pick up child:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Names of other children in family:

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Has child had previous experience away from home? Yes ( ) No ( )

If yes, please explain:

Are your Child's immunizations up to date? Yes ( ) No ( )

If no, please explain:

*Note: attach a copy of immunization record*

Does child have any known health problems? Yes ( ) No ( )

(If yes, attach documentation)

Check (√) any of the following illnesses the child has had:

- Asthma  Earaches  Mumps  Whooping Cough  Bronchitis  
 Eczema  Pneumonia  Polio  Chicken Pox  Frequent Colds  
 Convulsions  Measles  Influenza  Diphtheria  Tonsillitis  
 Other:

Please list any injuries child has had:

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Does your child have any known allergies? Yes  No

If yes, what are they and what are your child's symptoms:

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Does your child take any medication on a regular basis? Yes  No

If yes, please list the name of the medication(s) and the medical condition for which it is taken:

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Do you have any outstanding concerns? Yes  No  If yes, please comment:

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Please indicate the days of your availability to volunteer: **(Registration Form will not be valid if this section is not filled)**

Monday  Tuesday  Wednesday  Thursday  Friday

CEEP Donation (Checks payable to Chinmaya Mission Los Angeles). Please Note that Chinmaya Early Education Program (CEEP) donation is not refundable. Check the option preferred. **A registration fee of \$50 will be charged each trimester.**

My child will be attending the 3 days a week (M/W/F) program.

My child will be attending the 5 days a week (8:55am-12:55pm) program.

Payment Method

Credit Card \_\_\_\_\_  MasterCard  Visa

Credit Card Number

\_\_\_\_\_

Name as it appears on card Expiry Date Number on back of card

Credit Card Billing Address (mandatory)

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

NOTE: When paying by credit card, there will be an additional \$10.00 Processing Fee.

Check \_\_\_\_\_

Number Date

Cash \_\_\_\_\_

Date

I am a member Chinmaya Mission where my child(ren) attend Balvihar program of CMLA. I understand and abide by the principles, philosophy and culture of Chinmaya Mission.

( ) I am not a member of Chinmaya Mission of Los Angeles. To co-authorize, I have requested the following member of Chinmaya Mission Los Angeles whose child(ren) attend Balvihar program of CMLA:

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(Signature of co-authorizing member of CMLA)

Patron ID# \_\_\_\_\_

I certify to the best of my knowledge that the statements made by me in this document are true.

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(Date) (Signature of father/guardian)

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(Date) (Signature of mother/guardian)

Chinmaya Mission Los Angeles  
14451 Franklin Ave, Tustin, California 92780  
Tel: (714) 832-7669

***Permission Slip/Medical Release***

I give permission for my child to join the CMLA sponsored activity – Chinmaya Early education Program (CEEP). I hereby release CMLA, its staff and volunteers from any responsibility and liability for any illness or injury that my child may sustain during this activity.

I hereby authorize an adult Chinmaya Mission (CMLA) volunteer/ CEEP volunteer to take whatever emergency measures that are judged necessary for the care and protection of my child and all the medical information provided by me is true to my knowledge.

In the event of an emergency, I understand that my child will be transported by a local emergency unit for treatment, if deemed necessary by a CMLA/CEEP volunteer. In certain medical situations, the local emergency resource may be contacted prior to contacting the child's parent or physician.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_