

**ST. CHRISTOPHER EPISCOPAL CHURCH  
MOTHERS' DAY OUT  
PROGRAM INFORMATION AND POLICIES  
(REV. 01/14/2021)**

Children three months through five years of age are eligible to attend our program. Responsible, loving adults will supervise them in play/learning activities. Activities will include general pre-school type activities such as story time, music, show and tell, arts and crafts, playtime, and age-appropriate educational activities. Additionally, seasonal activities, and special interest activities will be offered throughout the school year.

MDO operates on Tuesdays and Thursdays, September through May, from 10:00 A.M. to 2:00 P.M. **Children must be picked up no later than 2:00 so that teachers can leave their rooms by 2:15.** We will follow the Clear Creek Independent School District schedule of operation, unless otherwise specified.

**FEES**

A registration fee of \$80.00 per child is due at the time of registration. The monthly tuition fee is \$175.00 for the first child enrolled and \$165.00 for each additional child. Tuition is due on the first Tuesday or Thursday of the month, but no later than the 10th of each month, unless prior arrangements are made, and will not be pro-rated for partial attendance except for new students enrolling mid-month. A \$25.00 late fee may be charged for tuition paid after the 10<sup>th</sup> of the month. Registration and tuition are non-refundable fees that are subject to change.

**MEDICAL AND REGISTRATION FORMS**

Each child must have a completed registration and medical form on file in order to attend the program. No child will be admitted to the program without completed paperwork. ***CHILDREN FOR WHOM MEDICAL FORMS ARE NOT RECEIVED WILL NOT BE PERMITTED TO ATTEND.*** Your consideration in this matter is greatly appreciated.

**HEALTH POLICY**

No child will be permitted to attend MDO when visibly ill. If a child should become ill while at MDO, parents will be contacted and advised that the child needs to be picked up. Any child who has run a fever must be free of fever 24 hours prior to returning to MDO. If antibiotics have been prescribed, children will need to be on the medication a minimum of 24 hours prior to returning. Children will not be permitted to attend if they are vomiting, have diarrhea, bad coughs or colds, dark cloudy or green mucous, or any communicable illness. Your cooperation in this matter will help promote the good health of all children in our program. We reserve the right to refuse admittance to any child who appears to be ill.

## ATTENDANCE

Please notify us as soon as possible if your child will not be attending MDO for any reason. This will enable us to accommodate children who wish to drop in when space is available. It is also helpful to know in advance when children will be out for extended periods of time.

**Upon enrollment to the program you have committed to pay full tuition each month September through May. If you decide to withdraw from the program, tuition will only be waived if written notification is received 30 days prior to the intended last day, otherwise full tuition will remain due.**

## CLOTHING AND POSSESSIONS

*All clothing and possessions must be clearly labeled with the child's name.* The MDO staff will label any items not labeled. Children still in diapers should be in "easy access" clothing to facilitate diaper changing. Each child should bring disposable diapers if applicable (not yet toilet-trained) and a complete change of clothing for use if needed.

## FOOD GUIDELINES

Each child should bring a nutritious box lunch and a drink. Babies will be fed according to their parent's instructions. Enough liquids should be sent with babies to cover the amount the child would usually consume in four hours. The following requirements should be followed for safety and practicality:

1. Cut all food, especially hot dogs, Vienna sausages and grapes, into small bite-sized pieces.
2. Lunches high in sugar content are discouraged. Sending a sweet for dessert is acceptable.
3. Drinks should be sent in containers that discourage spillage. Red juices are discouraged as they stain when spilled.

## BEHAVIOR POLICY

The well-being and safety of each child in our program is of primary concern. It is our policy to re-direct and/or distract a child whose behavior needs redirection. When verbal correction and redirection does not stop the behavior, the child will be given a short "time out" period to help correct the behavior. When needed, depending on the severity of and/or recurrence of a behavior problem, parents may be contacted to enlist their help in correcting it. A child who persists in unacceptable behavior without any visible improvement may be asked to leave the program. The following are examples of areas of concern regarding behavior:

1. No hurtful behavior, i.e. biting, hitting, or kicking.
2. No spitting
3. No disruptive behavior that consistently diverts staff attention from the group as a whole.

Please feel free to contact us at 281-554-8602 (MDO Direct Line and Recorder)

**ST. CHRISTOPHER MOTHERS' DAY OUT ENROLLMENT FORM**

**2021/2022**

Birth Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell phone \_\_\_\_\_

Person(s) other than parents authorized to pick up your child:

\_\_\_\_\_  
(Name) (Relationship) (Phone)

\_\_\_\_\_  
(Name) (Relationship) (Phone)

Any persons NOT AUTHORIZED to pick up your child:

Person(s) to contact in case of emergency if parent or guardian cannot be reached:

\_\_\_\_\_  
(Name) (Relationship) (Phone)

\_\_\_\_\_  
(Name) (Relationship) (Phone)

Do you have any special needs or concerns for your child. \_\_\_\_\_ Explain on back.

Name of Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

I have received, read and read a copy of St. Christopher Mothers' Day Out Program Information and Policies (rev. 1/24/2019)

Signature

Date

**ST. CHRISTOPHER MOTHERS' DAY OUT MEDICAL FORM**

**2021/2022**

NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY, STATE, \_\_\_\_\_  
ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

Please fill out this page completely - then take it to your physician for written statement that the child has been examined within the previous twelve (12) months. (See reverse side.)

TO BE FILLED OUT BY PARENT OR GUARDIAN:

**Have or subject to (check if yes)**

\_\_\_\_\_ **Asthma**      \_\_\_\_\_ **Fainting spells**      \_\_\_\_\_ **Convulsions**  
\_\_\_\_\_ **Diabetes**      \_\_\_\_\_ **Heart Trouble**      \_\_\_\_\_ **Allergy**  
\_\_\_\_\_ **Other**      \_\_\_\_\_ **None of the above**

**Please explain.** \_\_\_\_\_

**Has difficulty with: (check if yes):**

\_\_\_\_\_ **Eyes, ears, nose, throat**  
\_\_\_\_\_ **Lungs**  
\_\_\_\_\_ **Digestion**

**Has had:**

\_\_\_\_\_ **Measles**  
\_\_\_\_\_ **Mumps**  
\_\_\_\_\_ **Chicken Pox**  
\_\_\_\_\_ **Whooping Cough**

**Please explain.** \_\_\_\_\_

**Any conditions now requiring medication?** \_\_\_\_\_

**Any restriction of activity for medical or non-medical reason?** \_\_\_\_\_

**PARENT AUTHORIZATION**

This health history is correct so far as I know, and the child herein described has permission to engage in all prescribed activities, except as noted by the physician and me. In the event I cannot be reached in an emergency, I hereby give permission to the MDO staff to obtain medical attention for my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(SEE REVERSE SIDE)

SHOT RECORD/DATES\*\*

DPT/DT	_____	_____	_____	_____
POLIO	_____	_____	_____	_____
CHICKENPOX	_____	_____	_____	_____
MMR	_____	_____	_____	_____
HIB	_____	_____	_____	_____
HEPATITIS A	_____	_____	_____	_____
HEPATITIS B	_____	_____	_____	_____
ROTA VIRUS	_____	_____	_____	_____
PNEUMOCOCCAL	_____	_____	_____	_____
MENINGOCOCCAL	_____	_____	_____	_____
INFLUENZA	_____	_____	_____	_____

TUBERCULIN TEST: \_\_\_\_\_ RESULTS: \_\_\_\_\_

This child was examined by me on \_\_\_\_\_ (date) and found to be free of all contagious and transmissible diseases and is physically able, with exceptions noted, to participate in the MDO program.

EXCEPTIONS: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Phone Number

\*\*Based on Recommended Schedule for Persons Aged 0 – 6 Years (United States)