



Enrollment Agreement

12901 NW 27th Avenue*786-416-9940
Early Childhood Education Center

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information

If your child is participating in school age child care, please complete form titled, "School Age Child Care Supplemental Enrollment Form"

Child's Information

Child's first name		Child's middle name		Child's last name		Child's nickname		
Age	Sex	Child's primary language		Parent/guardian/sponsor primary language				
Child's home address				City		State		Zip
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Grade		School phone		
School address				Drop off time		Pick-up time		

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Home email			Work email			Work phone			
Employer	Employer address			City		State		Zip	Work hours
Other parent/guardian/sponsor		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Home email			Work email			Work phone			
Employer	Employer address			City		State		Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]

Person #1		Relationship to child		Home phone		Cell phone			
Home address				City		State		Zip	
Home email			Work email			Work Phone			
Employer	Employer address			City		State		Zip	Work hours
Person #2		Relationship to child		Home phone		Cell phone			
Home address				City		State		Zip	
Home email			Work email			Work Phone			
Employer	Employer address			City		State		Zip	Work hours
Person #3		Relationship to child		Home phone		Cell phone			
Home address				City		State		Zip	
Home email			Work email			Work Phone			
Employer	Employer address			City		State		Zip	Work hours

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial _____ Staff initial _____ Date _____



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Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks _____

Child's Medical & Developmental History

- Does your child have any special medical conditions? No Yes Explain _____
- Does your child have any chronic illnesses? No Yes Explain _____
- Please list a brief history of your child's serious injuries and hospitalizations. _____
- Does your child have diabetes? No Yes *If yes, please attach care instructions from your physician.*
- Does your child have asthma? No Yes *If yes, please attach care instructions from your physician.*
- Will medication be administered regularly? No Yes *If yes, please attach care instructions from your physician.*
- Does your child have any special dietary needs? No Yes Explain _____
- Is your child able to fully participate in all activities? Yes No Explain _____
- Does your child have any physical restrictions? No Yes Explain _____
- Does your child function at the level of other children in his/her age group? Yes No Explain _____
- Is your child able to walk Yes No
- Can your child communicate his/her needs? Yes No
- Does your child need assistance at meal time? No Yes Explain _____
- Does your child rest during the day? No Yes
- Is your child toilet trained? No Yes
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc? No Yes Explain _____
- Does your child require on-to-one care/supervision on a regular basis for a significant period of time? No Yes Explain _____
- Does your child require any accommodations or modifications to fully and equally enjoy and participated in a group care setting?
 No Yes Explain _____

Illness History (please check all that apply)

- | | | |
|----------------------------------------------------|---------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Asthma/breathing problems | <input type="checkbox"/> Urinary track infections | <input type="checkbox"/> Other |
- Please attach care instructions from your physician for any of these illnesses.

Disease History (please check all that apply and add the date)

- | | | |
|---------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Chicken Pox (Varicella) _____ | <input type="checkbox"/> Bronchiolitis _____ | <input type="checkbox"/> Botulism _____ |
| <input type="checkbox"/> Measles Rubeola _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Haemophilus Influenza _____ |
| <input type="checkbox"/> Rubella (German Measles) _____ | <input type="checkbox"/> Pertussis (Whooping cough) _____ | <input type="checkbox"/> Meningococcal Infection _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Tetanus _____ | <input type="checkbox"/> Rabies _____ |
| <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Diphtheria _____ | <input type="checkbox"/> Bacterial Meningitis _____ |

Allergies (please list)

Medication Allergies	Reaction	Food Allergies	Reaction
_____	_____	_____	_____
Bee Stings Allergies	Reaction	Respiratory Allergies	Reaction
_____	_____	_____	_____
Other Allergies	Reaction	Are any of these allergies life-threatening? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____		

Please attach care instructions from your physician for any life-threatening allergies...

Miscellaneous Screenings and Tests (please check all that apply and add the date of last screening)

- | | | |
|----------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Vision _____ | <input type="checkbox"/> Developmental _____ | <input type="checkbox"/> Tuberculosis (PPD) _____ |
| <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Aptitude _____ | <input type="checkbox"/> Sickle Cell Anemia _____ |
| <input type="checkbox"/> Speech _____ | <input type="checkbox"/> Educational _____ | <input type="checkbox"/> Other _____ |

To the best of my knowledge the information contained above is accurate.
Parent initial _____ Staff initial _____ Date _____



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Medical Information (continued)

Child's name	Birth date
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Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone
Physician's practice address	City	State
Preferred hospital/clinic for emergency care	City	State
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number
----------------------------------------	---------------	------------------------------------------	---------------

Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state requirements. You may do this at <http://www.nnii.org/vaccineInfo/index.cfm#state> Bold any immunization below that is a requirement.]**

Anthrax	Influenza	Pneumococcal disease	Smallpox
Diphtheria	Lyme Disease	Polio	Tetanus
Haemophilus influenzae type b (Hib)	Measles	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	Mumps	Rubella	Varicella (Chickenpox)
Human Papillomavirus (HPV)	Pertussis (Whooping Cough)	Shingles (Herpes Zoster)	Yellow Fever

Additional Medical Policies

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations. **Initial**

2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs. _____
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious. _____
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*. _____

Emergency Medical Authorization & Consent

- In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician. **Initial**

- In case of a medical emergency, I agree that my child may receive first aid and/or CPR. _____
- In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel. _____
- In case of a medical emergency, I will be responsible for the emergency medical expenses. _____
- In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. _____

I give my permission to this center to apply sunscreen and insect repellent to my child. *Please check which product you will permit.* **Initial**

I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name. _____

I have special instructions for the application process. None _____

Parent initial _____ Staff initial _____ Date _____



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Rate Agreement and Contract

Child's name Birth date

Hours of Operation

Regular operating hours are Monday through Friday from 6:45 AM to 6:00 PM except closings for various holidays, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures. The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on TV or radio stations. If it becomes necessary to close early, we will contact you or someone listed in the Emergency Contact and Release, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for child care are as follows:

Table with 6 columns: Day of week, Start time, AM/PM, End time, AM/PM, Comments. Rows for Monday through Friday.

I would prefer to make tuition payments on a [] weekly [] bi-weekly [] monthly Basis to include a weekly \$10 late fee.

Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

- Starting on _____ a fee of \$ _____ is due weekly on Monday. If another payment arrangement is made with the Director a late payment fee will be applied at \$10 a week.
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization, contagious illness, or absence at the request of a doctor (a written doctor's note is required to receive credit).
- I agree to pay the full tuition in advance of services rendered.
- I agree to pay the full tuition fee even if my child is absent for one or more days.
- A late fee of \$_10 is due if tuition is not received on time.
- A non-refundable registration fee of \$ 65 is due yearly.
- A late pick-up fee of \$ 5 per minute for first minute and \$1 for each additional minute per family is due if my child is not picked up before closing.
- Accounts two weeks in arrears may result in immediate termination of service.
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip will be required.
- All returned checks or ACH transactions (automatic debits) will be charged a fee up to the maximum amount allowed by law. Two or more returned checks or ACH transactions will result in my account being place on "money order only" status.
- A receipt for income tax purposes will only be provided upon request.
- I agree to sign up online under procare to review and pay my account online.

Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Parent initial _____ Staff initial _____ Date _____



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Other Agreements (continued)

Child's name	Birth date
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Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center.

Initial _____

Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.

Initial _____

I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.

Information contained in the **Parent Handbook** may be subject to change.

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement* and the *Parent Handbook*.

Primary Parent/Guardian/Sponsor Signature	Date	Center Staff Signature	Date
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School Age Child Care Supplemental Enrollment Form

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Enrollment Information					
Child's Information					
Child's first name		Child's middle name		Child's last name	
Child's nickname					
Age	Sex	Child's primary language		Parent/guardian/sponsor primary language	
Child's home address			City	State	Zip
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Grade	School phone
School address			Drop off time		Pick-up time
Child will be attending: <input type="checkbox"/> Morning Care <input type="checkbox"/> Afternoon Care <input type="checkbox"/> Summer Camp					
My Child is allowed to walk (3 rd grade and older*): <input type="checkbox"/> To School from Child Care <input type="checkbox"/> From School to Child Care					
*Note: [Child care center name] is not liable for the child until he/she arrives at the program or after the child has left the program to walk to/from school.					

After School Activities Information

Complete the information below to provide us with details about after school activities your child is participating in. Please complete a separate Transportation and School Activity form for each activity.

Transportation and After School Activity					
My child is transported to school via:			My child is transported from school via:		Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:					
Child participates in the following after school activities (list all):					
Type of Activity:					
Day of the week child is attending activities (circle all that apply): M T W Th F					
Time period of activity:					
Day:	Day:	Day:	Day:	Day:	Day:
Start Time:	Start Time:	Start Time:	Start Time:	Start Time:	Start Time:
End Time:	End Time:	End Time:	End Time:	End Time:	End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:					

Transportation and After School Activity					
My child is transported to school via:			My child is transported from school via:		Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:					
Child participates in the following after school activities (list all):					
Type of Activity:					
Day of the week child is attending activities (circle all that apply): M T W Th F					
Time period of activity:					
Day:	Day:	Day:	Day:	Day:	Day:
Start Time:	Start Time:	Start Time:	Start Time:	Start Time:	Start Time:
End Time:	End Time:	End Time:	End Time:	End Time:	End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:					

Your child's safety is our number one priority. **1 World Learning Center** will not release children from the program without the above information **in writing**.

Parent / Guardian Signature

Date