

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

Enrollment Information									
Child's Information							Date of Admission:		
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 public 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, relationship, and ages of siblings									
<b>Parent/guardian/sponsor</b>			Relationship to child		Cell Phone		Social Security Number		
Home address if different from above				City		State		Zip	
Primary Email			Work email			Work phone			
Employer	Employer address			City		State		Zip	Work hours
<b>Other parent/guardian/sponsor</b>			Relationship to child		Cell Phone		Social Security Number		
Home address if different from above				City		State		Zip	
Primary email			Work email			Work phone			
Employer	Employer address			City		State		Zip	Work hours
Child Emergency Contact and Release Information/Transportation Plan (do not include parents/guardians/sponsors/center staff)									
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.]									
<b>Person #1</b>			Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip	
Primary email			Work email			Work Phone			
Employer	Employer address			City		State		Zip	Work hours
<b>Person #2</b>			Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip	
Primary email			Work email			Work Phone			
Employer	Employer address			City		State		Zip	Work hours
<b>Person #3</b>			Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip	
Primary 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 \_\_\_\_\_

## Child's Experiences and Habits

Has your child been in childcare previously? If so, where did they attend?

### Experiences with Others:

1. What are some of the ways the child plays at home? \_\_\_\_\_  
\_\_\_\_\_
2. Does the child play with children from other families? \_\_\_\_\_ How? \_\_\_\_\_  
\_\_\_\_\_
3. How does the child react when they do not get their way? \_\_\_\_\_  
\_\_\_\_\_
4. Does the entire family spend time together during the day? \_\_\_\_\_  
\_\_\_\_\_

### Eating Habits

1. At what times does your child eat: breakfast \_\_\_\_\_ lunch \_\_\_\_\_ dinner \_\_\_\_\_ between meal snacks \_\_\_\_\_
2. Does child feed themselves? \_\_\_\_\_
3. What is the child's general attitude towards eating? \_\_\_\_\_
4. If the child refuses to eat, how is this handled and by whom? \_\_\_\_\_  
\_\_\_\_\_
5. Favorite Foods: \_\_\_\_\_
6. Disliked Foods: \_\_\_\_\_
7. Specific Food Allergies: \_\_\_\_\_

*If the child is an infant, please attach a feeding schedule with information about breastmilk/formula, bottle schedule, etc.*

### Sleep Habits

1. Child has their own room. \_\_\_\_\_ Shares room with \_\_\_\_\_
2. At night, the child sleeps from \_\_\_\_\_ to \_\_\_\_\_, with an average hours of sleep per night: \_\_\_\_\_
3. During the day, child naps from \_\_\_\_\_ to \_\_\_\_\_; other \_\_\_\_\_
4. Attitude towards going to sleep at night: \_\_\_\_\_
5. Attitude towards napping: \_\_\_\_\_
6. If there is difficulty, how is this handled and by whom? \_\_\_\_\_  
\_\_\_\_\_
7. Are there any habits that the child has associated with laying down? \_\_\_\_\_
8. Is bed wetting an issue? \_\_\_\_\_ At night? \_\_\_\_\_ At nap time? \_\_\_\_\_
9. If so, how is this handled and by whom? \_\_\_\_\_  
\_\_\_\_\_

### Toileting Habits

1. Is your child toilet trained? \_\_\_\_\_ Can your child take themselves to the restroom? \_\_\_\_\_
2. Does your child tell you when they need to go? \_\_\_\_\_ Does the child go willingly? \_\_\_\_\_
3. Can your child manage their own clothing while at the toilet? \_\_\_\_\_
4. Can your child change their own clothes? \_\_\_\_\_
5. Words that are used for: Urinating \_\_\_\_\_ Bowel Movements \_\_\_\_\_

## Speech and Physical Growth

1. How well does the child talk? \_\_\_ well, \_\_\_ fairly well \_\_\_ not very well \_\_\_ not at all
2. Is the child read to on a regular basis? \_\_\_\_\_ How often? \_\_\_\_\_
3. At what age did the child: Creep \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_
4. What are some words that you would use to describe your child? \_\_\_\_\_  
\_\_\_\_\_
5. Is there any other information that you believe we should know about your child: \_\_\_\_\_  
\_\_\_\_\_

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Medical Information

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

### Child's Medical & Developmental History

1. Does your child have any special medical conditions?  No  Yes Explain \_\_\_\_\_
2. Does your child have any chronic illnesses?  No  Yes Explain \_\_\_\_\_
3. Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
4. Does your child have diabetes?  No  Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma?  No  Yes *If yes, please attach care instructions from your physician.*
6. Will medication be administered regularly?  No  Yes *If yes, please attach care instructions from your physician.*
7. Does your child have any special dietary needs?  No  Yes Explain \_\_\_\_\_
8. Is your child able to fully participate in all activities?  Yes  No Explain \_\_\_\_\_
9. Does your child have any physical restrictions?  No  Yes Explain \_\_\_\_\_
10. Does your child function at the level of other children in his/her age group?  Yes  No Explain \_\_\_\_\_
11. Is your child able to walk?  Yes  No
12. Can your child communicate his/her needs?  Yes  No
13. Does your child need assistance at mealtime?  No  Yes Explain \_\_\_\_\_
14. Does your child rest during the day?  No  Yes
15. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.?  No  Yes Explain \_\_\_\_\_
16. Does your child require one-to-one care/supervision on a regular basis for a significant period?  No  Yes Explain \_\_\_\_\_
17. Does your child require any accommodations or modifications to fully and equally enjoy and participate 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 tract infections | <input type="checkbox"/> Other            |

*Please attach care instructions from your physician for any of these illnesses.*

### Child's Medical Care Provider

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

### Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number
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### Child's Allergies and Allergy History *(please detail reaction or potential reaction on indicated line)*

Medication: \_\_\_\_\_  
Insect Stings: \_\_\_\_\_  
Food: \_\_\_\_\_  
Respiratory Allergies: \_\_\_\_\_  
Other: \_\_\_\_\_

Are any of these allergies' life threatening? \_\_\_\_\_

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Medical Information (continued)

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 childcare regulations. Initial \_\_\_\_\_
2. I agree to provide information to the childcare 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 childcare 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 1 hour 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. \_\_\_\_\_
- I prefer this hospital: \_\_\_\_\_ or \_\_\_\_\_.
- 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. \_\_\_\_\_

## Sunscreen Permission

- I give my permission to this center to apply  sunscreen and  insect repellent to my child. *Please check which products 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  do not have special instructions for the application process. \_\_\_\_\_

## Rate Agreement and Contract

Child's name	Birth date
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## Hours of Operation

Regular operating hours are **6:30 am to 5:30 pm**, except closings for various holidays, and inclement weather as described in the Parent Handbook. Please consult the current calendar for holidays. There is no reduction in tuition because of center closures.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all, it will be announced on News Channel 5, HiMama and the TCDS Facebook page. 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. Please do not rely on one method as technology does glitch

## Scheduled Attendance

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

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Does your child participate in any therapies, recurring appointments, extracurricular events, etc. that may/would interfere with this projected schedule? Please detail below.

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

**Initial**

- Starting on \_\_\_\_\_ a fee of \$ \_\_\_\_\_ is due weekly.
- Tuition is due and payable by Monday, 8:30 am to secure week services.
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absences.
- 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 \$50, per week, is due if tuition is not received on time.
- A non-refundable registration fee of \$85 is due yearly.
- A late pick-up fee of \$5 per minute per child is due if my child is not picked up before closing.
- Accounts two weeks in arrears may result in immediate termination of service.
- The center may offer events or experiences that are an additional fee. The center will not supply the money for my child to participate.
- All returned checks or ACH transactions (automatic debits) will be charged a fee of \$30. Two or more returned checks or ACH transactions will result in my account being placed on "cash only" status.
- A 2-week written notice is required for any child being withdrawn from the program and I understand tuition is still due during this time.
- A receipt for income tax purposes will only be provided for accounts in good standing.

**Other Agreements**

**Private Employment Acknowledgement and Release**

**Initial**

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 to or sanctioned by this center. This center shall remain harmless from any such arrangement.

**Parent Declarations**

- I received a summary of the licensing requirements.
- I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents.)
- I visited the facility prior to enrolling my child, my pre-enrollment visit was conducted on \_\_\_\_\_.
- I received a copy of The Community Day School's Parent Handbook and Payment and Policy Contract, and I have signed their copy, verifying by receipt, my understanding and agreement of their content.
- I authorize the agency to transport my child as specified in the transportation plan section.

\_\_\_\_\_  
Primary Parent/Guardian/Sponsor Signature

\_\_\_\_\_  
Date

**Contract Approval**

I certify that I have completed this application in its entirety and that I have read, understand, and accept all the terms and conditions described in this *Application, Parent Handbook, Payment and Policy Contract*.

\_\_\_\_\_  
Primary Parent/Guardian/Sponsor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Staff Signature

\_\_\_\_\_  
Date