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** |
| **Child’s Information** |
| Child’s first name | Child’s middle name | Child’s last name | Child’s nickname |
| Age | Date of Birth | Child’s primary language | Parent/guardian/sponsor primary language |
| Child’s home address | City | State | Zip |
| Child’s mailing address | City | Date of enrollment |  |
| **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 |
|  |  | Work Phone |
| Employer | Employer address | City | State | Zip | Work hours |
| **Person #2** | Relationship to child | Home phone | Cell phone |
| Home address | City | State | Zip |
|  |  | Work Phone |
| Employer | Employer address | City | State | Zip | Work hours |
| **Person #3** | Relationship to child | Home phone | Cell phone |
| Home address | City | State | Zip |
|  |  | 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.

**Preferred Communication method (Please Check one) \_\_\_\_\_\_ In Child’s Cubby OR \_\_\_\_\_\_\_ E-mail address**

|  |
| --- |
| **Medical Information** |
| Child’s name | Birth date | Height | Weight | Hair color | Eye color |
| 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. Does your child have any physical restrictions? □ No □ Yes Explain  |  |
|  |  |
| 9. Does your child function at the level of other children in his/her age group? □ Yes □ No Explain  |  |
|  |  |
| 10. Was your child premature □ Yes □ No If yes by how much? |  |
| 11. Can your child communicate his/her needs? □ Yes □ No  |  |
| 12. Does your child need assistance at meal time? □ No □ Yes Explain |  |
|  |  |
| 13. Does your child rest during the day? □ No □ Yes  |  |
| 14. Is your child toilet trained? □ No □ Yes  |  |
| 15. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc? □ No □ Yes Explain |
|  |  |
|  |
| **Illness History** *(please check all that apply)* |
| □ Vision problems | □ Nosebleeds | □ Seizures |
| □ Hearing problems | □ Skin rashes | □ Mouth sores |
| □ Constipation | □ Sore throats | □ Fainting |
| □ Diarrhea | □ Ear infections | □ Persistent cough |
| □ Asthma/breathing problems | □ Urinary track infections | □ Other |  |
| *Please attach care instructions from your physician for any of these illnesses.* |
|  |
| **Disease History** *(please check all that apply and add the date)* |
| □ Chicken Pox (Varicella) |  | □ Bronchiolitis |  | □ Botulism |  |
| □ Measles Rubeola |  | □ Pneumonia |  | □ Heamophilus Influenza |  |
| □ Rubella (German Measles) |  | □ Pertussis (Whooping cough) |  | □ Meningococcal Infection |  |
| □ Mumps |  | □ Tetanus |  | □ Rabies |   |
| □ Scarlet Fever |  | □ Diphtheria |  | □ 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?**  | □ **Yes**  | □ **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)* |
| □ Vision |  | □ Developmental |  | □ Tuberculosis (PPD) |  |
| □ Hearing |  | □ Aptitude |  | □ Sickle Cell Anemia |  |
| □ Speech |  | □ Educational |  | □ Other |  |  |  |
|  |  |  |  |  |  |  |  |
| **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 |
| **Medical Information(Continued)** |
| **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)* |
| **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. Annually updated | **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 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. St. Vincent Hospital 822 W. 4th Leadville, CO 719-486-0230 |  |
|  |  |
| In case of a medical emergency, I will be responsible for the emergency medical expenses. |  |
|  |  |
| **Application of Sunscreen Authorization** |
| I give my permission to this center to apply □ Sunscreen □Lip Balm □Diaper cream and □Lotion to my child. *(Please check which product you will permit.)* | **Initial** |
|  |  |
| I understand that I must supply our own sunscreen, lip balm, diaper cream and lotion with a valid expiration date, and it will be labeled with my child’s name.I understand that if I do not supply my own Sunscreen and I have checked the sunscreen authorization, Bright Start Staff will apply sunscreen to my child.  | ­­­­­­­­­\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| I have special instructions for the application process. □ None □  |  |  |  |
|  |  |
| **Rate Agreement and Contract** |
| **Hours of Operation**  |
| Regular operating hours are **Monday through Friday from 7:30 AM to 5:30PM** except closings for various holidays, staff training 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 Lake County School District and on their 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. \_\_\_\_\_\_\_\_ |
|  |
| **Scheduled Attendance** (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion) |
| The days and hours that I wish to contract for child care are as follows: |
|  |
| Day of week | Start time | AM/PM | End time | AM/PM | Comments |
| Monday |  |  |  |  |  |
| Tuesday |  |  |  |  |  |
| Wednesday |  |  |  |  |  |
| Thursday |  |  |  |  |  |
| Friday |  |  |  |  |  |
| **Rate Agreement and Contract** |
| **Fee Policy** (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion) |
| - Starting on **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** a fee of **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** is due monthly. -– The daily drop-in rate is $50 for Full or Half-days for non-Tuition enrollment  |   | **Initial**­­­­­ |
|  |  |  |  |
| - Tuition is due and payable from the 1st to 6th of the month or the next businessday. Unless payment has been modified as noted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   |  |  |
|  |  |
| - Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), vacations or absence other than hospitalization. |  |
|  |  |
| - 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 per week** is due if tuition is not received on time. |  |
|  |  |
| - A non-refundable one-time registration fee of **$30** will be billed at time of enrollment. |  |
|  |  |
| - A late pick-up fee will be assessed as follows: $1 per minute after 5:30pm |  |
|  |  |
| - 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 may 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” or cash status.  |  |
|  |  |
| - A receipt for income tax purposes will be provided upon request. |  |
|  |  |
| **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. | **Initial** |
|  |  |
| **Miscellaneous** |
| I give permission for my child to sleep on a cot.  I give my permission for my child to participate in Creative Curriculm and ASQ screening. Occasionally, photos will be taken of the children at the center for use within the center, on our website, by the newspaper, in weekly emails, or on Bright Start Facebook page. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program. □Social Media Page □Weekly Class Email □Newspaper □Bright Start WebsiteI give my permission for my child to participate in supervised walking excursions near and around the center.  I give permission for Bright Start Learning Center to include children’s names, parent names, and contact information in the BSLC directory. | 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 **Family 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 *Family Handbook*. |
|  |  |  |  |  |  |  |  |
| Primary Parent/Guardian/Sponsor Signature  | Date | Center Staff Signature  | Date |