

CHILD'S NAME: _____	CHILD'S DATE OF BIRTH: _____
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PARENT/GUARDIAN INFORMATION

ADMISSION DATE: _____

MOTHER/GUARDIAN

FIRST NAME: _____ M.I. _____ LAST NAME: _____

ADDRESS: _____

HOME PHONE: () _____ CELL PHONE: () _____ OFFICE PHONE: () _____

EMAIL: _____ DRIVER'S LICENSE #: _____

OCCUPATION: _____ EMPLOYED BY: _____

WORK ADDRESS: _____ WORK HOURS: _____

CUSTODIAL PARENT (IF MARRIED, MARK BOTH PARENTS) MOTHER'S S.S. #: _____

PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED OTHER _____

FATHER/GUARDIAN

FIRST NAME: _____ M.I. _____ LAST NAME: _____

ADDRESS: _____

HOME PHONE: () _____ CELL PHONE: () _____ OFFICE PHONE: () _____

EMAIL: _____ DRIVER'S LICENSE #: _____

OCCUPATION: _____ EMPLOYED BY: _____

WORK ADDRESS: _____ WORK HOURS: _____

CUSTODIAL PARENT (IF MARRIED, MARK BOTH PARENTS) FATHER'S S.S. #: _____

PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED OTHER _____

CHILD INFORMATION

1ST CHILD

FIRST NAME: _____ M.I. _____ LAST NAME: _____

NAME CHILD PREFERS TO BE CALLED: _____ GRADE/CLASS: _____

CHILD'S ADDRESS: _____

GENDER: MALE FEMALE DATE OF BIRTH: _____ CHILD'S S.S. #: _____

2ND CHILD

FIRST NAME: _____ M.I. _____ LAST NAME: _____

NAME CHILD PREFERS TO BE CALLED: _____ GRADE/CLASS: _____

CHILD'S ADDRESS: _____

GENDER: MALE FEMALE DATE OF BIRTH: _____ CHILD'S S.S. #: _____



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CARE INFORMATION

HEIGHT:	WEIGHT:	HAIR COLOR:	EYE COLOR:
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Our goal is to provide your child excellent education and care. We have a few questions that will help us be better prepared to meet your child's individual needs. Please indicate if your child receives any of the following supports:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Communication Device | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Feeding tube | _____ |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Visual support | _____ |
| <input type="checkbox"/> Applied Behavior Analysis | <input type="checkbox"/> Auditory support | _____ |
| <input type="checkbox"/> Mobility device | | _____ |

Would you like your child's therapists to deliver services at the center? Yes No

Is there anything else we need to know about your child to ensure he or she can be well supported by our staff? _____

List of current medications: _____

MY CHILD'S MEDICAL CARE PROVIDER

MEDICAL CARE PROVIDER NAME: _____ PRACTICE/CLINIC NAME: _____
 PROVIDER ADDRESS: _____ PHONE: _____
 PREFERRED HOSPITAL/CLINIC: _____ DATE OF LAST PHYSICAL EXAMINATION: _____
 DENTIST NAME: _____
 DENTIST ADDRESS: _____ PHONE: _____
 HEALTH INSURANCE PROVIDER AND POLICY NUMBER: _____

MY CHILD'S ALLERGIES

- MEDICATIONS REACTION: _____
 FOOD REACTION: _____
 RESPIRATORY REACTION: _____
 BEE STING REACTION: _____
 OTHER REACTION: _____

ARE ANY OF THE ALLERGIES SEVERE OR LIFE-THREATENING? YES NO
 (IF YES, PLEASE TALK TO YOUR CENTER DIRECTOR ABOUT COMPLETING AN ALLERGY PLAN.)



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EMERGENCY CONTACTS & AUTHORIZED PICKUP PERSONS:

1ST CONTACT/PICK UP

FIRST NAME: _____ M.I. _____ LAST NAME: _____
 PHONE: _____ RELATIONSHIP TO CHILD: _____
 PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _
 ABLE TO PICK UP ALL CHILDREN IN THE FAMILY
 NOT ABLE TO PICK UP THE FOLLOWING CHILDREN: _____

2ND CONTACT/PICK UP

FIRST NAME: _____ M.I. _____ LAST NAME: _____
 PHONE: _____ RELATIONSHIP TO CHILD: _____
 PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _
 ABLE TO PICK UP ALL CHILDREN IN THE FAMILY
 NOT ABLE TO PICK UP THE FOLLOWING CHILDREN: _____

3RD CONTACT/PICK UP

FIRST NAME: _____ M.I. _____ LAST NAME: _____
 PHONE: _____ RELATIONSHIP TO CHILD: _____
 PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _
 ABLE TO PICK UP ALL CHILDREN IN THE FAMILY
 NOT ABLE TO PICK UP THE FOLLOWING CHILDREN: _____

4TH CONTACT/PICK UP

FIRST NAME: _____ M.I. _____ LAST NAME: _____
 PHONE: _____ RELATIONSHIP TO CHILD: _____
 PREFERRED PIN NUMBER FOR CHECKING IN/OUT (4 DIGITS, NUMBERS ONLY): 1ST CHOICE _ _ _ _ 2ND CHOICE _ _ _ _
 ABLE TO PICK UP ALL CHILDREN IN THE FAMILY
 NOT ABLE TO PICK UP THE FOLLOWING CHILDREN: _____

PERMISSION

DO YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE FIRST AID CARE IF NECESSARY? _____
 DO YOU GIVE PERMISSION FOR THE STAFF TO APPLY SUNSCREEN (SPF 15+) TO YOUR CHILD? _____
 DO YOU GIVE PERMISSION FOR YOUR CHILD TO PARTICIPATE IN WATER ACTIVITIES? _____
 LIFEJACKET REQUIRED: YES NO
 DO YOU GIVE PERMISSION FOR YOUR CHILD TO BE TRANSPORTED DURING FIELD TRIPS? _____
 DO YOU GIVE PERMISSION FOR YOUR CHILD TO BE TRANSPORTED TO/FROM SCHOOL TO THE FACILITY? _____



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MEDICAL ACKNOWLEDGMENTS

1. **Medication** I will provide written permission for center staff to administer medication with written instructions from me or the child's health care provider, as permitted by local child care licensing regulations. I will complete and sign authorization forms. I will provide the medication in its original container (with the pharmacist's label for prescriptions).
2. **Immunizations** I will provide the center with updated immunization information or an exemption for my child.
3. **Nurse/Health Consultant** Child care centers in some states are required to engage the services of a Nurse/Health Consultant to review health policies and procedures and children's records. I agree my child's records may be reviewed by the nurse/health consultant.
4. **Illness** If center staff notifies me that my child is ill, I will pick up my child as soon as possible and no later than one (1) hour after being contacted. If my child contracts a contagious illness, I understand that my child may return only when he or she is well, as described in the Parent Handbook.
5. **Emergencies** In case of an emergency, I understand that center staff will attempt to contact me immediately. I also authorize center staff to:
 - Consult the physician or dentist named above.
 - Administer first aid and/or cardiopulmonary resuscitation.
 - Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility.
 - Obtain any emergency medical, surgical or dental treatment deemed necessary by medical authorities.
 - Transport my child to a local emergency shelter in the event of an emergency evacuation of the center.

SCHEDULES / TRANSPORTATION / TUITION

CENTER HOURS

The center is open from 6:30 a.m. to 6:00p.m., Monday through Friday. We will be closed New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving and day after, as well as Christmas Day. We also dedicate time every year for professional development. Your Center Director will inform you when your center will be closed for these training days. The center will be open whenever possible on a regularly scheduled day, except in the case of severe weather or other emergency. Tuition is not reduced as a result of center closures.

SCHEDULE AND TRANSPORTATION ACKNOWLEDGMENTS

1. **Transportation Changes** I agree to notify the center if my school-age child does not need to be picked up from school or will not arrive by scheduled school bus on a particular day.
2. **Regular Schedule** Tuition is based on the child's regular schedule. I will be charged additional tuition if my child's attendance increases beyond this schedule. If my child's schedule changes in any way, I will notify the center immediately. Tuition and fees are not pro-rated for illness, holidays, or emergency closures. I agree to pay the full tuition even if my child is absent for one or more days, except for pre-arranged "reservation weeks."
3. **Absences** I will notify the center by 9:00 am when my child will be absent.
4. **Child Not Picked Up** If I fail to pick up my child and/or contact the center, and I or another authorized person cannot be reached within _____ minutes after closing time, center staff may release my child to the custody of child protective services or other local authorities.

TRANSPORTATION INFORMATION (FOR SCHOOL-AGE CHILDREN ONLY)

SCHOOL: _____ GRADE: _____

SCHOOL PHONE: _____ SCHOOL ADDRESS: _____

SCHOOL START TIME: _____ SCHOOL END TIME: _____



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TUITION AND FEE INFORMATION

My Tuition is: _____ Monthly

- **Late Payment Fee** All tuition is due in advance of services rendered. If tuition is not paid in advance, a late fee of \$_____ will be charged.
- **Registration Fee** A nonrefundable annual registration and/or equipment fee of \$_____ is due at the time of enrollment and payable each year. If my child has withdrawn from the program and subsequently re-enrolls, a new registration and/or equipment fee is due at that time.
- **Reservation Week Fee** I agree to pay the full tuition fee even if my child is absent for one or more days; however, for each full calendar week my child is absent, the tuition fee will be discounted _____% as a reservation fee. I understand I will receive _____ reservation weeks per year and the payment for reservation fees are due in advance of the absence. The center requests a two-week notice of an intended vacation.
- **Late Pick-Up Fee** A late pick-up fee of \$_____ per _____ per child will be assessed when a child is left beyond the center's operating hours. The late pick-up fee does not constitute an agreement to provide after hours service.
- **Additional Fees** Your child may have the opportunity to participate in special programs, summer programs, or field trips with an additional fee.
- **School-Age Care Fees** If your child regularly attends elementary school but school is not in session due to a school holiday, closure, or early release, he or she may attend a full/half day at the center for an additional \$_____ per day or \$_____ per half day.
- When school is not in session for the entire week, full-time tuition is \$_____ per _____.

SCHEDULED ATTENDANCE

DAY	HOURS OF CARE (e.g., 8 am–5 pm)
SUNDAY	
MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	

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FINANCIAL & OTHER TERMS

FINANCIAL ACKNOWLEDGMENTS

- 1. Payment Authorizations** I authorize The Footprint Foundation to:
- Use my tuition and fee payment checks to initiate electronic debits to my checking account.
 - Attempt to collect on returned checks up to two additional times.
 - Electronically debit my account for the amount of any returned item and a returned item fee in the maximum amount allowed by state law.
 - Initiate one-time ACH debits to my checking account for any amounts owed that become past due (upon written notice from the center.) My payment authorizations will remain in effect until I give the center written notification to terminate the authorization.
- 2. Financial Obligations** I authorize As the parent/guardian signing this Enrollment Agreement all amounts due are ultimately my responsibility. Accounts two weeks in arrears may result in immediate termination of services; however, upon payment, enrollment may be reinstated with applicable paid tuition and registration fee. Overdue accounts may be referred to a collection agency. I am responsible for all account balances, plus reasonable collection and attorney fees associated with the collection of the account. Payments from families with prior unpaid returned checks must be in the form of a money order or cashier's check. Families with returned check activity may be subject to immediate termination of services. Any prepaid balance of \$25 or less which remains at the time of my child's disenrollment will not be refunded unless requested in writing within 90 days. _____ written notice is required prior to the last day of attendance.

PHOTOGRAPHY OF CHILDREN

_____ I give permission for my child to be photographed and videoed in the center and during program functions and field trips. I understand that photographs/videos may be taken by center staff or by other parents/guardians, and I consent to the use of these photographs/videos for communication purposes, such as communication with families.

OTHER TERMS

_____ **Assessments and Screenings** I give permission for my child to participate in early learning assessments and screenings administered by The Footprint Foundation. The results of these assessments will be used by The Footprint Foundation to measure my child's progress and may be used to evaluate the program. I will have access to all results of these assessments.

_____ **Babysitting** We don't encourage private babysitting by our staff. If you hire any of our employees, however, how that works is solely between you and the employee. The Footprint Foundation is not responsible for those services.

_____ **Communications** I give The Footprint Foundation permission to communicate with me by telephone, text, e-mail, or other means. I understand The Footprint Foundation privacy policy applies to the information I provide.

_____ **Resolving Disputes** We do not expect any disagreements. However, we agree that, in the unlikely event we have one we can't resolve, any dispute or claim will be submitted to nonbinding mediation before beginning arbitration, litigation, or any other proceeding. We agree to act in good faith to participate in mediation and to identify a mutually acceptable mediator. All parties to the mediation will share equally in its costs. I have read, understand and accept all of the terms in this Agreement. I will promptly update any information provided for in this Agreement if any information changes. Center management does not have the authority to change the terms of this Agreement (other than inserting information where required) either verbally or in writing. A child may be dis-enrolled by the center without prior notice if, in the sole opinion of the center, it is in the best interest of the child or the center. We reserve the right to alter policies and/or program at any time. The terms of this Agreement, including the tuition and fees, are subject to change in whole or in part by the center with 30 days' notice.

This Agreement will begin on: _____

Center Director Signature: _____ Date: _____

Child's Name: _____

