



Enrollment Contract

Parent/Guardians' Name(s) _____

Child's Name _____ Sex ___ M / F

Date of Birth _____ Current Age _____ Start Date _____

Phone Number _____

Address _____

Email Address _____

Has your child previously attended a child care facility? YES NO

*Name of prior center attended (optional) _____

Enrolling:

4 Days/wk 5 Days/wk Rate _____

Schedule:

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday

(Reminder: 9 hours of care between 7am-5:15pm)

Drop-off Time: _____ Pick-up Time: _____

Lunch Program \$20/wk: YES NO

Extended Care: 30 min/day, \$20 1 hour/day, \$37

I'd like to pay: Weekly Bi-Weekly Monthly

I acknowledge the purpose of my 4 week deposit is to secure a designated start date AND schedule for my child. Should I choose to enroll elsewhere and do not give an appropriate 4 week notice, I will not be refunded as The Academy will have turned away potential students. Two weeks of tuition will be applied to my child's first two weeks, and 2 weeks will be applied to their last two weeks.

Parent Signature _____ Date _____

Director Signature _____ Date _____

The Academy for Active Learners LLC
134 Warren Avenue
Portland, ME 04103
207.854.4000
Mindy@theacademyforactivelearners.com

Parent Handbook Agreement

I have received and read The Academy for Active Learners Parent Handbook. I understand and agree to the policies and procedures outlined.

Please initial the following stating you've read and agree to these policies:

- _____ Health & Illness Policy
- _____ Holiday Schedule & Policy
- _____ Tuition & Late Fee Policies
- _____ Withdrawal Policy
- _____ Nut-Free Policy
- _____ Lunch Program Policy

Name of child/children _____

Name (Printed) _____

Signature _____ Date _____



Emergency Contact List

Mother

Name: _____

Home Address: _____

Work Address: _____

Company Name: _____

Phone Numbers: Home _____ Work _____ Cell _____

Notes (regarding schedules, etc.):

Father

Name: _____

Home Address: _____

Work Address: _____

Company Name: _____

Phone Numbers: Home _____ Work _____ Cell _____

Notes (regarding schedules, etc.):

Additional Emergency Contact Numbers & Authorized Pick-up/Drop-off Care-givers

In the event of an emergency, the following contacts may be called to pick-up or care for your child.

Name: _____ Relationship to child: _____

Phone Numbers: Home _____ Work _____ Cell _____

Name: _____ Relationship to child: _____

Phone Numbers: Home _____ Work _____ Cell _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Custody Agreement (if applicable) Please discuss any custody arrangements or people that should be marked as someone that should NOT have contact with the child or be released to on back.



Authorization to Treat a Minor

I (we) the undersigned parent, parents or legal guardian of _____ a minor(_____), do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provision of the Medicine Practice Act, of a Dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Maine, Department of Health and Human Services. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

Date of last tetanus booster: _____

Allergies to drugs or food: _____

Any special medications or pertinent information: _____

Preferred Hospital: _____

Child's physician: _____

Child's dentist: _____

Insurance company and policy number: _____

Signature of Mother, Father, or Legal Guardian:

Signature: _____ Date: _____

Signature: _____ Date: _____



Permission to Photograph

I, _____, give my permission for The Academy for Active Learners to photograph my child, _____, for the following purposes:

Type of use:	Grant Permission	Decline Permission
Still Photographs:		
Display in provider's personal scrapbook		
Give photographs to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and perspective clients		
Display still photos on facility's website		
Use still photos in promotional materials		
Post to Academy Facebook page		
Videos:		
Give to current parents		
Display video on facility website		
Use videos in promotional material		
Post to Academy Facebook page		

*no names will be displayed on our website

I understand that it is my responsibility to update this form in the even that I no longer wish to authorize one of more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed: _____ Date: _____
 (Parent or Guardian signature)



Basic Release Form

For my child: _____

This release allows The Academy for Active Learners staff to administer CPR if needed.

It is understood that the person doing so is certified.

It also allows them to apply the following non-prescriptions:

Diaper rash ointment or cream

Sunscreen

First aid creams

Burn creams as needed

Other: _____

It is agreed that I will be informed of any of the above as soon as possible if used or performed.

Prescription medications will be administered at the discretion of The Academy for Active Learners staff on an individual basis and must be in original containers. If your child is under two years of age the medication must be accompanied by a doctor's note. A medication log will be used for this and kept in your child's file.

It is also understood and permission given that my child may be driven in the Academy for Active Learners staff vehicle if the need arise.

This release also releases the child and persons as stated above from any liability from any accident or injury, which may occur regarding the above.

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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Statement of Health Status- Enrollment Form

The childcare facility must obtain for every child who enrolls a signed and dated statement of the child's current health status, which indicates the child's abilities and/or limitations to participate in regularly scheduled childcare program. This report is to be filled out by a licensed physician or other healthcare professional that has seen the child in the last twelve months.

Child's Name: _____ Sex: Male / Female

Address: _____

Past Illnesses: (Please check those the child has had and give approximate dates)

Chicken Pox: _____ Rheumatic Fever: _____ Diabetes: _____

Whooping Cough: _____ Rubeloa: _____ Asthma: _____

Mumps: _____ Poliomyelitis: _____ Rubella: _____

Hayfever: _____ Epilepsy: _____

Other: _____

Surgery, Accidents, or Illnesses:

Date	Type	Time of Recovery

Describe any physical condition requiring the facilities special attention: _____

Medications Prescribed: _____

Allergies: _____

If tuberculin test given: Date: _____ Results: _____

If chest x-ray given: Date: _____ Results: _____

Vision: _____ Hearing: _____

Date of my most recent examination of the child: _____

*****Please record immunizations and dates administered on the Maine Department of Health Certificate of Immunization and attach to this form*****

Please print clearly:

Name of Physician/Healthcare professional: _____

Address: _____

Phone Number: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____