Enrollment Contract

Parent Name(s)_____**Start Date**_____

Child's Name_____ Sex M / F DOB_____

Classroom Entering: Ocean Farm Jungle Forest Town

Phone Numbers_____

Address_____

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

*Name of prior center attended_____

Set Schedule Details: Center Hours: 7am- 5:30pm

Reminder: Standard Tuition Provides 9 hours of Child Care. If additional time is needed, extended care options are available. ($1/min fees apply to late pick ups and early drop offs)

4 Days/wk 5 Days/wk Drop-off Time:_____ Pick-up Time: _____

Changes to this schedule must be discussed with staff

____Monday ____Tuesday ____Wednesday ____Thursday ____Friday

Lunch Program $25/wk: YES N **Extended Care:** 30 min/day, $20 1 hour/day, $37 None

Payment Info: Tuition Rate_____ Bi-Weekly - autopay set up on Brightwheel app

Email:_____

Invoices are sent out the week payment is due. Payments are due on Fridays by noon.

$25 late fee will be applied if not paid on time.

Deposit Details: Total $_____

_____

Deposit Due:_____Sent to Pat:_____

☐ 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 not join as planned and do not give an appropriate 8 week notice, I will not be refunded. Two weeks of my child's deposit will be applied to their first two weeks of tuition. The remaining two weeks of the deposit will be applied to their last two weeks of tuition. $195 enrollment fee is non-refundable.

Parent Signature_____Date_____

Director Signature_____Date_____

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 that you have read and agree to these policies:

_____Deposit (2 weeks of deposit applied to first 2 weeks, save others for last 2 weeks)

_____ Health & Illness Policy

_____ Holiday Schedule & Policy

_____ Tuition, Late Fee Policies & Late Drop-Off Policy

_____ Discipline & Negative Behavior Policy

_____ Withdrawal/Termination Policy

_____ Nut-Free Policy & Mandated Reporter

_____ Lunch Program Policy

_____ Alcohol/Smoking/Firearms Policy

Name of Child/Children: _____

Parent/Guardian (Printed):_____

Signature: _____ Date:_____

Emergency Contact List

Parent 1

Name:_____

Home Address:_____

Work Address:_____

Company Name: _____

Phone Numbers: Cell _____ Work_____

Please indicate preferred contact method and any other notes:

Parent 2

Name:_____

Home

Address:_____

Work

Address:_____

Company Name:

_____

Phone Numbers: Cell_____ Work_____

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 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:_____

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		
Display in facility's scrapbook or bulletin boards, shown to current and perspective clients		
Display still photos on facility's website *no names will be displayed		
Use still photos in promotional materials. *no names will be displayed		
Post to Brightwheel App		

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

Name of 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 child care 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:_____

**Dr to complete, sign & return along with copy of immunization records to address below.
Thank you!

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:_____ Asthma:_____ Rubella:_____

Mumps:_____ Poliomyelitis:_____ Hayfever:_____

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

Name of Physician/Healthcare professional:_____

Address:_____

Phone Number:_____

Physician Signature:_____ **Date:**_____

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