

# Enrollment Agreement

# Most Sacred Heart of Jesus Preschool/ Daycare

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 childcare licensing regulations.

Enrollment Information									
<b>Child's Information</b>									
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 school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name			Grade		School phone		
School address				Drop off time			Pick up time		
<b>Family Information</b>									
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
<b>Other</b> 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
<b>Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)</b>									
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	
Home 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	
Home 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	
Home 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 \_\_\_\_\_

**Medical Information**

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

**Child's Medical & Developmental History**

- Does your child have any special medical conditions? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child have any chronic illnesses? ☐ No ☐ Yes Explain \_\_\_\_\_
- Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
- Does your child have diabetes? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Does your child have asthma? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Will medication be administered regularly? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Does your child have any special dietary needs? ☐ No ☐ Yes Explain \_\_\_\_\_
- Is your child able to fully participate in all activities? ☐ Yes ☐ No Explain \_\_\_\_\_
- Does your child have any physical restrictions? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child function at the level of other children in his/her age group? ☐ Yes ☐ No Explain \_\_\_\_\_
- Is your child able to walk ☐ Yes ☐ No \_\_\_\_\_
- Can your child communicate his/her needs? ☐ Yes ☐ No \_\_\_\_\_
- Does your child need assistance at meal time? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child rest during the day? ☐ No ☐ Yes \_\_\_\_\_
- Is your child toilet trained? ☐ No ☐ Yes \_\_\_\_\_
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child require one-to-one care/supervision on a regular basis for a significant period of time? ☐ No ☐ Yes Explain \_\_\_\_\_
- 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.

**Disease History** (please check all that apply and add the date)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chicken Pox (Varicella) _____  | <input type="checkbox"/> Bronchiolitis _____              | <input type="checkbox"/> Botulism _____                |
| <input type="checkbox"/> Measles Rubeola _____          | <input type="checkbox"/> Pneumonia _____                  | <input type="checkbox"/> Haemophilus Influenza _____   |
| <input type="checkbox"/> Rubella (German Measles) _____ | <input type="checkbox"/> Pertussis (Whooping cough) _____ | <input type="checkbox"/> Meningococcal Infection _____ |
| <input type="checkbox"/> Mumps _____                    | <input type="checkbox"/> Tetanus _____                    | <input type="checkbox"/> Rabies _____                  |
| <input type="checkbox"/> Scarlet Fever _____            | <input type="checkbox"/> Diphtheria _____                 | <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Vision _____  | <input type="checkbox"/> Developmental _____ | <input type="checkbox"/> Tuberculosis (PPD) _____ |
| <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Aptitude _____      | <input type="checkbox"/> Sickle Cell Anemia _____ |
| <input type="checkbox"/> Speech _____  | <input type="checkbox"/> Educational _____   | <input type="checkbox"/> Other _____              |

To the best of my knowledge the information contained above is accurate.

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

**Medical Information (continued)**

Child's name	Birth date
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**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 Immunization History** (please attach a copy of your child's immunization records)

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state requirements. You may do this at <http://www.immunize.org/states/> .**

Anthrax	Influenza	<b>Pneumococcal disease</b>	Smallpox
<b>Diphtheria</b>	Lyme Disease	<b>Polio</b>	<b>Tetanus</b>
<b>Haemophilus Influenzae type b (Hib)</b>	<b>Measles</b>	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
<b>Hepatitis B</b>	<b>Mumps</b>	<b>Rubella</b>	<b>Varicella (Chickenpox)</b>
Human Papillomavirus (HPV)	<b>Pertussis (Whooping Cough)</b>	Shingles (Herpes Zoster)	Yellow Fever

**Additional Medical Policies**

1. Within 30 days, 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.	<b>Initial</b>
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 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the <i>Child Emergency Contact and Release</i> .	

**Emergency Medical Authorization & Consent**

In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , and lastly my physician.	<b>Initial</b>
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.	
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.	

I give my permission to this center to apply <input type="checkbox"/> sunscreen and <input type="checkbox"/> alcohol-based hand sanitizer. <i>Please check which products you will permit.</i>	<b>Initial</b>
I understand that I must supply my own sunscreen with a valid expiration date, and it will be labeled with my child's name.	
I <input type="checkbox"/> have <input type="checkbox"/> do not have special instructions for the application process.	

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

**Rate Agreement and Contract**

Child's name

Birth date

**Hours of Operation**

Regular operating hours are **Monday-Friday 7:30am-5:30pm** except closings for various holidays, 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 KDKA news site and through Brightwheel App. 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**

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

Day of week	Daycare Start time	Daycare End time	Preschool start time	Preschool end time	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

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

- Preschool: Starting on \_\_\_\_\_ a fee of \$ \_\_\_\_\_ is ☐ monthly. Initial \_\_\_\_\_
- Daycare: Starting on \_\_\_\_\_ a fee of **\$ 7.50 hourly**. \_\_\_\_\_
- Tuition (Preschool) is due and payable 14 days prior to the next month paid by Brightwheel app/cash/check. ☐ Daycare is paid every 14 days through Brightwheel app/cash/check. ☐ Preschool payment must be paid by the 1<sup>st</sup> of the month or next business day. \_\_\_\_\_
- Tuition (Preschool) is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absence other than hospitalization, or absence at the request of a doctor (a written doctor's note is required to receive credit). \_\_\_\_\_
- I agree to pay the full tuition in advance of services rendered. (Preschool) \_\_\_\_\_
- I agree to pay the full tuition fee even if my child is absent for one or more days. (Preschool) \_\_\_\_\_
- A late fee of \$25.00 is due if tuition is not received on time. (Preschool and Daycare) \_\_\_\_\_
- A non-refundable registration fee of \$75.00 is due yearly. \_\_\_\_\_
- A late pick up fee of \$5.00 per minute per child (not to exceed \$100.00 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. (Preschool & Daycare) \_\_\_\_\_
- 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 of \$30.00. Two or more returned checks or ACH transactions will result in my account being placed on "money order only"/ cash status. \_\_\_\_\_
- A 2-week written notice is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit and tuition. (Preschool) \_\_\_\_\_

**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 to or sanctioned by this center. This center shall remain harmless from any such arrangement. Initial \_\_\_\_\_

**Media Release**

Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program. Initial \_\_\_\_\_

**Other Agreements (continued)**

Child's name

Birth date

**Walking Excursions**

I give my permission for my child to participate in supervised walking excursions near and around the center.

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 Director 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*.\_\_\_\_\_  
Primary Parent/Guardian/Sponsor Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Center Staff Signature\_\_\_\_\_  
Date**Contract Approval- Revised/Updated**I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement*.\_\_\_\_\_  
Primary Parent/Guardian/Sponsor Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Center Staff Signature\_\_\_\_\_  
Date