Enrollment Agreement *(Infant-4 years old)*

The Success Learning Academy

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs.

Enrollment Information

Child's Information

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
Is your child's ethnicity Hispanic / Latino/Spanish Origin regardless of race? □ Yes □ No	What is your child's race?	Does your child have an Individualized Education Plan (IEP)? If so, Attach a copy. □ Yes □ No	Does your child receive any of the following services? Check one: □ CAPS □ SSI □ Food Stamps □ Medicaid □ TANIF □ No
Current School Name	Teacher	Grade	

Family Information

List family members

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 us 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		
Home email	Work email	Work Phone			
Employer	Employer address	City	State	Zip	Work hours
Person #2	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
Person #3	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

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. Is your child able to fully participate in all activities? □ Yes □ No Explain _____
9. Does your child have any physical restrictions? □ No □ Yes Explain _____
10. Does your child function at the level of other children in his/her age group? □ Yes □ No Explain _____
11. Is your child able to walk □ Yes □ No _____
12. Can your child communicate his/her needs? □ Yes □ No _____
13. Does your child need assistance at meal time? □ No □ Yes Explain _____
14. Does your child rest during the day? □ No □ Yes
15. Is your child toilet trained? □ No □ Yes
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? □ No □ Yes Explain _____
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? □ No □ Yes Explain _____
18. 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)*

□ Vision problems	□ Nosebleeds	□ Seizures
□ Hearing problems	□ Skin rashes	□ Mouth sores
□ Constipation	□ Sore throats	□ Fainting
□ Diarrhea	□ Ear infections	□ Persistent cough
□ Asthma/breathing problems	□ Urinary tract 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		□ Haemophilus 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 - attach).*

□ Vision		□ Developmental		□ Tuberculosis (PPD)	
□ Hearing		□ Aptitude		□ Sickle Cell Anemia	
□ Speech		□ Educational		□ 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

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

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

Additional Medical Policies

	Initial
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.	
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 TWS, 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 *Child Emergency Contact and Release* to pick up your child.	

Emergency Medical Authorization & Consent

	Initial
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.	
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.	

Parent initial _____ Staff initial _____ Date _____

Enrollment Agreement **_The Success Learning Academy_**

Rate Agreement and Contract

Child's name	Birth date

Hours of Operation

Regular operating hours are **6:00 am – 6:30 pm** 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 the 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 your local news . 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.

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

		Initial
- Starting on _____ a fee of **$**_____ is due	□ weekly. □ bi-weekly. □ monthly.	
- Tuition is due and payable	□ every Friday or by Monday 9:00 a.m. (a late fee is due after 9:00) □ every other Friday or by the second Monday by 9:00 a.m.	
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization, contagious illness, 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.		
- I agree to pay the full tuition fee even if my child is absent for one or more days.		
- A late fee of $10.00 per day is due if tuition is not received on time.		
- A non-refundable application fee of $75.00 is due yearly.		
- A late pick up fee of $1.00 per minute per child (not to exceed $60.00 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.		
- 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 agreement is required.		
- All returned checks or ACH transactions (automatic debits) will be charged a fee of $35,00. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status.		
- A two-week written notice is required for any child being withdrawn from the program.		
- A receipt for income tax purposes will be provided upon request.		
CHILD AND PARENT SERVICES (CAPS)/Temporary Assistance for Needy Families (TANIF)		
- Parents are responsible for paying their family fee every week and registration fees. If not, this will be reported to the case manager and Maximus.		

Other Agreements

Private Employment Acknowledgement and Release

	Initial
Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center is prohibited and this center shall remain harmless from any such arrangement.	

Media Release

	Initial
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.	

Parent initial _____ Staff initial _____ Date _____

Other Agreements *(continued)*

Child's name	Birth date

Handbook Acknowledgement

	Initial
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.	
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*.

Primary Parent/Guardian/Sponsor Signature	Date	Center Staff Signature	Date