

Enrollment Agreement

Mountain Valley Lutheran Preschool

Date _____

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 child care licensing regulations.

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		Date of Birth	
Child's home address/ mailing address				City		State	
						Zip	

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings—marital status of parents

Does your family have a church home?

Is your child baptized?

Parent/guardian/sponsor		Relationship to child		Home phone		Cell phone	
Home address if different from above				City		State	
						Zip	
Work phone			Email address				
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	
Work phone			Email address				
Employer		Employer address		City		State	
						Zip	
						Work hours	

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

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.]

Person #1		Relationship to child		Home phone		Cell phone	
Home address				City		State	
						Zip	
Work Phone			email				
Employer		Employer address		City		State	
						Zip	
						Work hours	
Person #2		Relationship to child		Home phone		Cell phone	
Home address				City		State	
						Zip	
Work Phone			email				
Employer		Employer address		City		State	
						Zip	
						Work hours	
Person #3		Relationship to child		Home phone		Cell phone	
Home address				City		State	
						Zip	
Work Phone			email				
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.*

Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
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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 on-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 participated 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 track 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 _____

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

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

Additional Medical Policies

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. **Initial**

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 *Child Emergency Contact and Release*. _____

Emergency Medical Authorization & Consent

- 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. **Initial**

- 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. _____

- Initial**
- I give my permission to this center to provide and apply sunscreen _____
- I prefer to provide my own sunscreen with a valid expiration date, and it will be labeled with my child's name. _____
- I have special instructions for the application process. None _____

Rate Agreement and Contract

Child's name

Birth date

Hours of Operation

Regular operating hours are **Monday through Friday from 7:30 AM to 5:30 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 center closures. 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 I am signed up for are the following:

___Monday ___Tuesday ___Wednesday ___Thursday ___Friday

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

- a fee of \$47/day is due monthly	Initial _____
- Tuition is due and payable on the First business day of the month.	_____
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization. Make up days are not available.	_____
- 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 \$15 is due if tuition is not received on time.	_____
- A non-refundable registration fee of \$50 is due yearly. A \$25 activity fee is also due with first tuition payment.	_____
- A late pick-up fee of \$1 per minute 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.	_____
-Two weeks' notice is needed prior to withdrawing my child from MVLP or two weeks' tuition payment may be paid..	_____
- 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 up to the maximum amount allowed by law. Two or more returned checks or ACH transactions will result in my account being place on "money order only" status.	_____
- A receipt for income tax purposes will be provided.	_____
-Preplanned absences may be sold to other enrolled families.	_____

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 or sanctioned by this center. This center shall remain harmless from any such arrangement.	Initial _____
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Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.	Initial _____
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Other Agreements *(continued)*

Child's name	Birth date
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Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center. Notes will be posted.	Initial
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Movies

Occasionally "G" rated movies may be shown for special occasions. I will be notified	Initial
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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 management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	_____
I understand that if my child attends MVLP he/she will be given instruction based on the doctrine of Mountain Valley Lutheran Church of the Wisconsin Lutheran Synod.	_____
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* and the *Family Handbook*. To the best of my knowledge, this information is true and correct.

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