

Enrollment Agreement

Mighty Bright Child Care Centers
Director – Tamara McAllister

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 Birth Date	
Age	Sex	Child's primary language			Enrollment Date		Withdrawal Date		
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		
Family Information									
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
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 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	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
2. Does your child have any chronic illnesses? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
3. Please list a brief history of your child's serious injuries and hospitalizations. _____					
4. Does your child have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
5. Does your child have asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
6. Will medication be administered regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
7. Does your child have any special dietary needs? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
8. Is your child able to fully participate in all activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____					
9. Does your child have any physical restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
10. Does your child function at the level of other children in his/her age group? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____					
11. Is your child able to walk <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. Can your child communicate his/her needs? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. Does your child need assistance at meal time? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
14. Does your child rest during the day? <input type="checkbox"/> No <input type="checkbox"/> Yes					
15. Is your child toilet trained? <input type="checkbox"/> No <input type="checkbox"/> Yes					
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
Illness History <i>(please check all that apply)</i>					
<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	
<i>Please attach care instructions from your physician for any of these illnesses.</i>					
Disease History <i>(please check all that apply and add the date)</i>					
<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 <i>(please list)</i>					
Medication Allergies		Food Allergies			
_____	Reaction _____	_____	Reaction _____		
Bee Stings Allergies		Respiratory Allergies			
_____	Reaction _____	_____	Reaction _____		
Other Allergies		Are any of these allergies life-threatening? <input type="checkbox"/> Yes <input type="checkbox"/> No			
_____	Reaction _____				
<i>Please attach care instructions from your physician for any life-threatening allergies.</i>					
Miscellaneous Screenings and Tests <i>(please check all that apply and add the date of last screening)</i>					
<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
Preferred hospital/clinic for emergency care	Phone	City
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State

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. **Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.**

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

Additional Medical Policies

1. Prior to enrollment, I must provide the center with an updated Health Care Professionals Statement 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. _____

Additional Consent

- I give my permission to this center to apply sunscreen and insect repellent to my child. *Please check which products you will permit.* **Initial**

- I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name. _____
- I have do not have special instructions for the application process. _____

Parent initial _____ Staff initial _____ Date _____

Rate Agreement and Contract

Child's name	Birth date
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Hours of Operation

Regular operating hours are **6:30AM UNTIL 6:00PM** except closings for various holidays, staff professional development, 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 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 and Meals Served

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

Day of week	Start time	AM/PM	End time	AM/PM	Meals served to my child while in care
Monday					<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack
Tuesday					<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack
Wednesday					<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack
Thursday					<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack
Friday					<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack

I would prefer to make tuition payments on a weekly bi-weekly monthly basis.

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

<ul style="list-style-type: none"> - A two-week deposit of \$ _____ is due prior to starting date - A fee of \$ _____ is due <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly. - Tuition is due and payable by 6:00pm <input type="checkbox"/> Every FRIDAY <input type="checkbox"/> the 1st and 15th of the month or next business day. <input type="checkbox"/> first business day of the month. - Tuition is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absence other than hospitalization, or absence for more than 5 days 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 \$35 is due if tuition is not received on time. - A non-refundable registration fee of \$100 is due yearly. - A late pick-up fee of \$2.00 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. - 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 \$50. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status. - A two (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. - A receipt for income tax purposes <input type="checkbox"/> will be provided so long as my account is in good standing with \$0 balance 	<p>Initial</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting, personal transport), 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.	<p>Initial</p> <hr/>
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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 and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.	<p>Initial</p> <hr/>
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Parent initial _____ Staff initial _____ Date _____

Other Agreements (continued)

Child's name	Birth date
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Water Activities

	<input type="checkbox"/> water table play	<input type="checkbox"/> sprinkler play
	<input type="checkbox"/> splashing or wading pool	

I give my consent for my child to participate in the following supervised water activities:

Walking Excursions and Field Trips

I give my permission for my child to participate in supervised walking excursions and Field Trips near, around the center and off site. **Initial**

Handbook Acknowledgement

I acknowledge receipt of the operational policies and 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. _____

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
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School Age Child Care Supplemental Enrollment Form Mighty Bright Child Care Centers

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
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
I give consent for my child to be transported and supervised by the operations employees (check all that apply): <input type="checkbox"/> to and from school <input type="checkbox"/> Fieldtrips				
My Child is allowed to walk (3 rd grade and older*): <input type="checkbox"/> To School from Child Care <input type="checkbox"/> From School to Child Care				
*Note: Mighty Bright Child Care Centers is not liable for the child until he/she arrives at the program or after the child has left the program to walk to/from school.				

After School Activities Information

Complete the information below to provide us with details about after school activities your child is participating in. Please complete a separate Transportation and School Activity form for each activity.

Transportation and After School Activity				
My child is transported to school via:		My child is transported from school via:		Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:				
Child participates in the following after school activities (list all):				
Type of Activity:				
Day of the week child is attending activities (circle all that apply): M Tu W Th F				
Time period of activity:				
Day:	Day:	Day:	Day:	Day:
Start Time:	Start Time:	Start Time:	Start Time:	Start Time:
End Time:	End Time:	End Time:	End Time:	End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:				

Transportation and After School Activity				
My child is transported to school via:		My child is transported from school via:		Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:				
Child participates in the following after school activities (list all):				
Type of Activity:				
Day of the week child is attending activities (circle all that apply): M Tu W Th F				
Time period of activity:				
Day:	Day:	Day:	Day:	Day:
Start Time:	Start Time:	Start Time:	Start Time:	Start Time:
End Time:	End Time:	End Time:	End Time:	End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:				

Your child's safety is our number one priority. Mighty Bright Child Care Centers will not release children from the program without the above information **in writing**.

Primary Parent/Guardian/Sponsor Signature

Date