

### Little Kids Club Enrollment

All information is <u>required</u>. If you have questions or need assistance, please contact Jennifer Ness, Program Director: 218-639-7105.

			//	//	
Child's Name D		Date	e of Birth	First Date of Attendance	
Circle one: Male / Female Cir		Circl	cle one: Full Time / Part Time		
Parent 1					
Parent Name			Relationsh	ip to Child	
Address			 Home Pho	 ne#	
City	State	Zip	Cell Phone	 #	
Employer			 Work Phor		
Department			Work Hour	s/Day	
Email address:					
Parent 2					
Parent Name			Relationsh	ip to Child	
Address			 Home Pho	 ne#	
City	State	Zip	Cell Phone	 #	
Employer			 Work Phor		
Department			Work Hour	s/Day	
Email address:					

### **Emergency Contacts** *if parent(s) cannot be reached. Must list two.*

Name			Relationship to Child
Address			Primary Phone#
City	State	Zip	Secondary Phone#
Name			Relationship to Child
Address			Primary Phone#
City	State	Zip	Secondary Phone#
Health Care Providers			
Medical Provider			Phone#
Dental Provider			

### **Parental Emergency Medical Consent**

This form is presented upon admission for treatment.

	//	//
Child's Name	Date of Birth	First Date of Attendance

Doctor

In the event that my child listed above may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to:

Hospital

or his/her designee to provide this care.

I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

### **Health Care Providers:**

Medical Provider	Phone#
Dental Provider	Phone#

### Parents/Guardians with whom child resides:

Parent/Guardian Name			Relationship to Child
Address			 Home Phone#
City	State	Zip	Cell Phone#
Employer			
Parent/Guardian Name			Relationship to Child
Address			 Home Phone#
City	State	Zip	Cell Phone#

Employer

Work Phone#

# Person(s) who are authorized to pick up child if parents/guardians are unavailable:

Name			Relationship to Child	
Address			 Home Phone#	
City	State	Zip		
Employer				
Name			Relationship to Child	
Address			 Home Phone#	
City	State	Zip		
Employer			 Work Phone#	

### Custody Restraints/Person(s) who may NOT pick up child:

Name	Relationship to Child		
Name	Relationship to Child		

Health Care Summary This form must be completed by Health Care Source.

	/ /	/	/
Child's Name	Date of Birth	First Date	e of Attendance
Parent(s)/Guardian(s):			
Date of last physical:// How long have you been seeing thi			
How frequently do you see this chil Does this child have any allergies (i If yes, please describe:	ncluding allergies to medica	ations)?: Y / N	
Is a modified diet necessary?: Y / N			
If yes, please describe: Is any condition present that might If yes, please describe:	result in an emergency?: Y	/ N	
Please indicate the status of the ch	ild's:		
Vision: H	earing:	Speech:	
Please list any important health pro	blems:		
lssue:	Treating provider::	atter	uires special ntion at center: Y / N Y / N
Other information halpful to the abi			Y / N
Other information helpful to the chi			
		1	1
Provider Signature		/ Date	/
Address:		Phone:	

This Page Left Intentionally Blank

### **About Your Child**

To help us better care for your child, please complete the following.

Child's Name: \_\_\_\_\_

- 1. Tell us a little bit about your child, such as likes, dislikes, temperament, favorites, etc.
- 2. Please list some of your child's favorite foods.
- 3. Please list foods your child dislikes.
- 4. Describe your child's napping habits (e.g. blanket, bear, thumb, etc.) and patterns (e.g. length of nap, cries self to sleep, likes back rubbed, etc.).
- 5. Are there any routines or habits we should be aware of (e.g. bites nails, pacifier, etc.)?
- 6. Are there issues outside of the center that staff should be made aware of (e.g. divorce, separation, death, etc.)?
- 7. Anything additional you'd like us to know about?

## This Page Left Intentionally Blank

### Little Kids Club Parent/Provider Contract

Child's Name:

Weekly Fee Please circle one

		<u>Toddler (16 mo. <i>until</i></u>	<u>3 yrs.)</u>	Preschool (3 - 5 yrs.)
	Full Time (weekly)	\$175.00		\$165.00
Schedule				
Monday		a.m./p.m. to		a.m./p.m.
Tuesday		a.m./p.m. to		a.m./p.m.
Wednesday		a.m./p.m. to		a.m./p.m.
Thursday		a.m./p.m. to		a.m./p.m.
Friday		a.m./p.m. to		a.m./p.m.
Average Wee	kly Hours:			

Please indicate any special circumstances (e.g.: every other week schedule):

All rates are based on a 9-hour day. Attendance over 9 hours in a day will be charged \$3.50 per hour additional. All payments are due on Friday of each week, regardless of attendance and/or closures. Failure to pay by the deadline will result in a \$20.00 late fee.

Note: Children enrolled in LKC who are also planning to attend WDC Preschool must be enrolled in the A.M. Preschool program only.

Based on the information above, I understand that my weekly fee is equal to **\$\_\_\_\_\_**. I understand that this fee is due by Friday of each week, regardless of attendance and/or closures. I understand that a late fee of \$20.00 will be added if payment is not received.

Signed: \_\_\_\_\_

### Little Kids Club Parent Release Agreement

### \*\*Please read, initial and sign below:

\_\_\_\_\_ I have received a copy of the fee schedule and have determined the number of days and fees associated with my child's schedule. I understand that if my child does not attend when he/she is scheduled, it is my responsibility to pay for that day.

\_\_\_\_\_ I agree to pay the last day of the week of my child's attendance each week.

\_\_\_\_\_ I am aware that I will be charged a late fee of \$20.00 for payments not received each week.

\_\_\_\_\_ I have received a copy of the LKC handbook. I understand that it is my responsibility to read through it prior to my child's enrollment.

\_\_\_\_\_ I authorize LKC staff to initiate emergency medical and dental care (i.e.: CPR/First Aid) and to call Emergency Personnel (911) if a need arises.

\_\_\_\_\_ I authorize LKC staff to contact Poison Control if a need arises, and to follow any guidelines they recommend for my child.

\_\_\_\_\_ I authorize LKC staff to apply sunscreen (which I will provide) to my child as needed.

\_\_\_\_\_ I authorized LKC staff to apply insect repellent (which I will provide) to my child as needed.

\_\_\_\_\_ I authorize LKC staff to apply diaper rash ointment (which I will provide) to my child as needed.

Parent Signature

Date

**Provider Signature**