Little Kids Club Enrollment

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

_____ ____/____/_____ ____/____/_____

Child's Name Date of Birth First Date of Attendance

Circle one: Male / Female Circle one: Full Time / Part Time

Parent 1

_____ _____

Parent Name Relationship to Child

_____ _____-_____-_____

Address Home Phone#

_____ _____-_____-_____

City State Zip Cell Phone#

_____ _____-_____-_____

Employer Work Phone#

_____ _____

Department Work Hours/Day

Email address: _____

Parent 2

_____ _____

Parent Name Relationship to Child

_____ _____-_____-_____

Address Home Phone#

_____ _____-_____-_____

City State Zip Cell Phone#

_____ _____-_____-_____

Employer Work Phone#

_____ _____

Department Work Hours/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 Phone#

Parental Emergency Medical Consent

This form is presented upon admission for treatment.

_____ ____/____/_____ ____/____/_____

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

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 | Doctor

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 | Work Phone#

_____ _____

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 Cell Phone#

_____ _____-_____-_____

Employer Work Phone#

_____ _____

Name Relationship to Child

_____ _____-_____-_____

Address Home Phone#

_____ _____-_____-_____

City State Zip Cell Phone#

_____ _____-_____-_____

Employer Work Phone#

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

_____ _____

Name Relationship to Child

_____ _____

Name Relationship to Child

_____ _____

Parent Signature **Date**

Health Care Summary

This form must be completed by Health Care Source.

_____ ____/____/_____ ____/____/_____

Child's Name Date of Birth First Date of Attendance

Parent(s)/Guardian(s): _____

Date of last physical: ____/____/_____

How long have you been seeing this child?: _____

How frequently do you see this child when he/she is not ill?: _____

Does this child have any allergies (including allergies to medications)?: Y / N

If yes, please describe: _____

Is a modified diet necessary?: Y / N

If yes, please describe: _____

Is any condition present that might result in an emergency?: Y / N

If yes, please describe: _____

Please indicate the status of the child's:

Vision: _____ Hearing: _____ Speech: _____

Please list any important health problems:

Issue:	Treating provider::	Requires special attention at center:
_____	_____	Y / N
_____	_____	Y / N
_____	_____	Y / N

Other information helpful to the child care program:

_____

_____

_____

_____

_____ ____/____/_____

Provider Signature **Date**

Address: _____ Phone: ____-____-_____

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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?

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Little Kids Club Parent/Provider Contract

Child's Name: _____

Weekly Fee *Please circle one*

	Toddler (16 mo. *until* 3 yrs.)	**Preschool** (3 - 5 yrs.)
Full Time (4-5 days/week)	$155.00	$145.00
Part Time (2-3 days/week)	$124.00	$116.00

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 Weekly Hours: _____

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

_____

_____

_____

Full time attendees are given priority over part time. 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: _____ Date: _____

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 **Date**