
Enrollment Agreement Form

(Child's Name



**THANK YOU FOR YOUR INTEREST IN VICTORY KIDS'
ACADEMY!!**

**FILL OUT COMPLETELY!! PLEASE DO NOT LEAVE
ANYTHING BLANK!!**

Enrollment Agreement

VICTORY KIDS' ACADEMY

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			
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
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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)*

- | | | |
|--|---|---|
| <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 _____ |

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 _____ |

To the best of my knowledge the information contained above is accurate.

Parent initial _____ Staff initial _____ Date _____

Enrollment Agreement

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*. Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it. _____

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 Phoebe Putney 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. _____

- 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 _____

Enrollment Agreement

Rate Agreement and Contract

Child's name _____

Birth date _____

Hours of Operation

Regular operating hours are **6:30a.m.-5:30p.m.** 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.

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 WMAZ. 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 and hours that I wish to contract for child care are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

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)

- Starting on _____ a fee of \$ _____ is due weekly. Initial _____
- Tuition is due and payable by 9a.m. Every Monday. _____
- 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 \$7 per day is due if tuition is not received on time. _____
- A non-refundable registration fee of \$35 is due yearly. _____
- A late pick up fee of \$15 per minute per child (not to exceed \$30 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 \$30. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status. _____
- A 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 will be provided. _____

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

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. Initial _____

Parent initial _____ Staff initial _____ Date _____

My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Evening Snack

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

My child is allergic to: _____

At a special request could the Academy _____

Victory Kids' Academy agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep. _____

Please take a brief moment to tell us about your child. Please let us know any information that will help us in caring for your child.

Enrollment Agreement

Other Agreements *(continued)*

Child's name

Birth date

Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center.

Initial _____

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.

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