# Enrollment Contract

**Parent Name(s)**_____**Start Date**_____

**Child's Name**_____ Sex M / F DOB_____

**Classroom Entering:** Ocean Farm Jungle Forest Town

Phone Numbers_____

Address_____

Has your child previously attended a child care facility? YES NO

*Name of prior center attended_____

**Set Schedule Details:** Center Hours: 7am- 5:30pm

Reminder: Standard Tuition Provides 9 hours of Child Care. If additional time is needed, extended care options are available. ($1/min fees apply to late pick ups and early drop offs)

4 Days/wk 5 Days/wk Drop-off Time:_____ Pick-up Time: _____

*Changes to this schedule must be discussed with staff*

____Monday ____Tuesday ____Wednesday ____Thursday ____Friday

**Lunch Program $20/wk**: YES N **Extended Care:** 30 min/day, $20 1 hour/day, $37 None

**Payment Info**: Tuition Rate_____/wk **I'd like to pay:** Bi-Weekly Monthly

**Email:**_____

Email invoices are sent out the week payment is due.

Payments are due on Fridays by noon. $25 late fee will be applied if not paid on time.

**Deposit Details:** _____

_____

_____

☐ I acknowledge the purpose of my 4 week deposit is to secure a designated start date AND schedule for my child. Should I choose to enroll elsewhere and do not give an appropriate 4 week notice, I will not be refunded. Two weeks of my child's deposit will be applied to their first two weeks of tuition. The remaining two weeks of the deposit will be applied to their last two weeks of tuition.

Parent Signature_____Date_____

Director Signature_____Date_____

# Parent Handbook Agreement

I have received and read The Academy for Active Learners Parent Handbook. I understand and agree to the policies and procedures outlined.

Please initial the following stating you've read and agree to these policies:

_____ Health & Illness Policy

_____Holiday Schedule & Policy

_____Tuition & Late Fee Policies

_____Withdrawal Policy

_____Nut-Free Policy

_____Lunch Program Policy

Name of child/children _____

Name (Printed) _____

Signature _____Date _____

The Academy for Active Learners LLC
134 Warren Avenue
Portland, ME 04103
207.854.4000
Mindy@theacademyforactivelearners.com

# Emergency Contact List

**Parent 1**

Name:_____

Home Address:_____

Work Address:_____

Company Name: _____

Phone Numbers: Cell _____ Work_____

| Please indicate preferred contact method and any other notes: |
|---|
| |

**Parent 2**

Name:_____

Home

Address:_____

Work

Address:_____

Company Name:

_____

Phone Numbers: Cell_____ Work_____

| Please indicate preferred contact method and any other notes: |
|---|
| |

**Additional Emergency Contact Numbers & Authorized Pick-up/Drop-off Care-givers**

In the event of an emergency, the following contacts may be called to pick-up or care for your child.

Name:_____ Relationship to child:_____

Phone Numbers: Home_____ Work_____ Cell_____

Name:_____ Relationship to child:_____

Phone Numbers: Home_____ Work_____ Cell_____

Printed Name:_____

Parent Signature:_____ Date:_____

**Custody Agreement** (if applicable) Please discuss any custody arrangements or people that should be marked as someone that should NOT have contact with the child or be released to on back.


# Authorization to Treat a Minor

I (we) the undersigned parent, parents or legal guardian of _____ (a minor), do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provision of the Medicine Practice Act, of a Dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Maine, Department of Health and Human Services. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

_____

Date of last tetanus booster: _____

Allergies to drugs or food: _____

Any special medications or pertinent information: _____

_____

Preferred Hospital: _____

Child's physician: _____

Child's dentist:_____

Insurance company and policy number:_____

Signature of Mother, Father, or Legal Guardian:

Signature:_____ Date:_____

# Permission to Photograph

I, _____, give my permission for The Academy for Active Learners to photograph my child, _____, for the following purposes:

| Type of use: | Grant Permission | Decline Permission |
|---|---|---|
| **Still Photographs:** | | |
| Display in provider's personal scrapbook | | |
| Give photographs to current clients | | |
| Display in facility's scrapbook or bulletin boards, shown to current and perspective clients | | |
| Display still photos on facility's website | | |
| Use still photos in promotional materials | | |
| Post to Academy Facebook page | | |
| **Videos:** | | |
| Give to current parents | | |
| Display video on facility website | | |
| Use videos in promotional material | | |
| Post to Academy Facebook page | | |

*no names will be displayed on our website

I understand that it is my responsibility to update this form in the even that I no longer wish to authorize one of more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:_____ Date:_____

(Parent or Guardian signature)

# Basic Release Form

Name of Child: _____

This release allows The Academy for Active Learners staff to administer CPR if needed. It is understood that the person doing so is certified.

It also allows them to apply the following non-prescriptions:

Diaper rash ointment or cream

Sunscreen

First aid creams

Burn creams as needed

Other: _____

It is agreed that I will be informed of any of the above as soon as possible if used or performed. Prescription medications will be administered at the discretion of The Academy for Active Learners staff on an individual basis and must be in original containers. If your child is under two years of age the medication must be accompanied by a doctor's note. A medication log will be used for this and kept in your child's file.

It is also understood and permission given that my child may be driven in the Academy for Active Learners staff vehicle if the need arise.

This release also releases child care and persons as stated above from any liability from any accident or injury, which may occur regarding the above.

Parent Signature:_____ Date:_____

Provider Signature:_____ Date:_____

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**Dr to complete, sign & return along with copy of immunization records to address below.
Thank you!

# Statement of Health Status- Enrollment Form

The childcare facility must obtain for every child who enrolls a signed and dated statement of the child's current health status, which indicates the child's abilities and/or limitations to participate in regularly scheduled childcare program. This report is to be filled out by a licensed physician or other healthcare professional that has seen the child in the last twelve months.

Child's Name:_____ Sex: Male / Female

Address: _____

**Past Illnesses:** (Please check those the child has had and give approximate dates)

Chicken Pox:_____ Rheumatic Fever:_____ Diabetes:_____

Whooping Cough:_____ Asthma:_____ Rubella:_____

Mumps:_____ Poliomyelitis:_____ Hayfever:_____

Epilepsy:_____ Other:_____

**Surgery, Accidents, or Illnesses:**

Date Type Time of Recovery

Describe any physical condition requiring the facilities special attention:_____

_____

Medications Prescribed:_____

Allergies:_____

If tuberculin test given: Date:_____ Results:_____

If chest x-ray given: Date:_____ Results:_____

Vision:_____ Hearing:_____

Date of my most recent examination of the child:_____

***Please record immunizations and dates administered on the Maine Department of Health Certificate of Immunization and attach to this form***

**Name of Physician/Healthcare professional:**_____

**Address:**_____

**Phone Number:**_____ **Fax:**_____

**Physician Signature:**_____ **Date:**_____

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