Dear New Family,

Welcome aboard! Enclosed is your enrollment package, to be completed and returned prior to your child's first day. Please read through your Parent Handbook carefully as it outlines many policies and procedures that you will be agreeing to on page 3. Please keep this handbook for your reference throughout the year, as it contains important information.

For your convenience, the following package is digital. Please fill out pages 2-7, print, sign and return to The Academy. The last page (8) should be sent to your child's physician. The physician's office can mail this form directly to us at the address listed below.

Invoices will be emailed one week prior to payment due date. Your payment due date will be the Friday morning before the child care period begins. For example: If you pay for bi-weekly, your payment will be due on Friday and you will pay for the following 2 weeks.

If payment is received past noon, there will be a $25 late fee charge.

Please complete the following info and submit along with a check made out to The Academy for Active Learners LLC for $95. One must be filled out for each individual child.

On behalf of our team at The Academy, I would like to welcome you to our family. If you have any questions about anything here at our learning center, please do not hesitate to contact me.

Thank you,
Mindy Brigham
Owner/Director
854-4000 ext. 1
mindy@theacademyforactivelearners.com

# Enrollment Contract

Parent/Guardians' Name (s)_____

Child's Name _____Sex _____

Date of Birth_____ Current Age_____ Start Date _____

Phone Number_____ **Classroom Entering**

Address_____

Email Address_____

Has your child previously attended child care facility? Select

*Name of prior center attended (optional) _____

Enrolling: Preschool (3-5) 4 days, $220/wk

Schedule: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

(Reminder: 9 hours of care between 7am – 5:15pm)
Drop-off Time: _____ Pick-Up Time: _____

Lunch Program $20/wk: Select Extended Care: None

I'd like to pay: Bi-Weekly

☐ 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.

Deposit Details - Internal Use only

Parent Signature _____

Director Signature _____

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

## 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** _____

# Emergency Contact List

PARENT 1 **Name:** _____

Home Address: _____

Work & Address: _____

Phone Numbers: Home _____Work _____Cell _____

Notes (regarding schedules, etc.):

PARENT 2 **Name:** _____

Home Address: _____

Work & Address: _____

Phone Numbers: Home _____Work _____Cell _____

Notes (regarding schedules, etc.):

***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: _____

Name: _____ Relationship to Child: _____

Phone Numbers: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

***CUSTODY ARRANGEMENT (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 or 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 & 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_____Phone:_____

Child's Physician: _____Phone:_____

Child's Dentist_____Phone:_____

Insurance Company and Policy Number:

_____

Signature of Father, Mother, or Legal Guardian:

_____Date: _____

_____Date: _____

# Permission to Photograph

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

| Types of use: | (Please check one) 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 prospective clients | ☐ | ☐ |
| Display still photos on facility's website | ☐ | ☐ |
| Use still photos in promotional materials | ☐ | ☐ |
| Post to Academy Facebook Page | ☐ | ☐ |
| **Videos:** | | |
| Give video to current parents | ☐ | ☐ |
| Display video on facility website | ☐ | ☐ |
| Use videos in promotional materials | ☐ | ☐ |
| Post to Academy Facebook Page | ☐ | ☐ |

* only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or 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

For my 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-prescription items:

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:_____

Provider signature:_____

# 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 health care professional that has seen this child in the last twelve months.

**Child's Name**:_____ **Sex**:_____ **Birthdate**:_____

**Address**:_____

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

Chicken Pox_____ Rheumatic Fever_____ Diabetes_____ Whooping Cough _____ Rubeloa _____

Asthma_____ Mumps_____ Poliomyelitis _____ Rubella_____ Hayfever_____

Epilepsy_____ Other_____

**Surgery/Accidents/Illnesses**

| Date | Type | Time of Recovery |
|---|---|---|
| | | |
| | | |
| | | |

Describe any physical condition requiring the facility's special attention:
_____

**Medications Prescribed**:_____

**Allergies**:_____

**If tuberculin test give**: Date_____ Results_____

**If chest x-ray give**: 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.**

**PLEASE PRINT CLEARLY**

Name of Physician/Health Care Professional:_____

Address:_____

Phone #:_____ Fax;_____

Physician's Signature:_____ Date: _____