



Office Use Only:

Start Date: _____

Withdrawal: _____

Recv'd By: _____

Child's Name _____ Gender _____ Age _____ Date of Birth _____

Home Address (Street) _____

City _____ State _____ Zip _____

ALLERGIES YES OR NO _____

Parent # 1 Name _____ Phone # _____

Parent # 1 Home Address (if different from child's) _____

City _____ State _____ Zip _____ Email _____

Parent #1 Social Security Number _____

Parent #1 Place of Employment _____ Work Phone # _____

Employer's Street Address _____ City _____ State _____ Zip _____

Parent # 2 Name _____ Phone # _____

Parent # 2 Home Address (if different from child's) _____

City _____ State _____ Zip _____ Email _____

Parent #2 Social Security Number _____

Parent #2 Place of Employment _____ Work Phone # _____

Employer's Street Address _____ City _____ State _____ Zip _____

Child's Living Arrangements: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Child's Legal Guardian(s): (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

The child may be released to the person(s) signing this agreement or to the following:

*Name _____
(Street-City-State-Zip)

Telephone # _____ Relationship to child _____
Other identifying information (if any) _____

*Name _____
(Street-City-State-Zip)

Telephone # _____ Relationship to child _____
Other identifying information (if any) _____

Person to contact in the case of emergency when parent or guardian cannot be reached:

Name _____ Telephone # _____ Relationship to child _____

Name _____ Telephone # _____ Relationship to child _____

Name _____ Telephone # _____ Relationship to child _____

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 currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

Parent Signature: _____ Date: _____



EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of Birth _____
suffer an injury or illness while in the care of **TINY TREASURES** and the facility is unable to contact me (us)
immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I
(We) shall assume responsibility for payment for services.

Child's doctor/Clinic name: _____

Doctor/Clinic Telephone #: _____ Preferred Hospital: _____

Parent/Guardian: _____
Signature

Facility Administrator: _____
Signature



Parental Agreements with Child Care Facility

1

TINY TREASURES agrees to provide care for _____
(Child's Name)

on M T W Th F from _____ am to _____ pm from _____ to _____
(Month) (Month)

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

Breakfast
AM Snack
Lunch
PM Snack
Dinner
Bedtime Snack

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.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans, and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

TINY TREASURES 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.

I authorize **TINY TREASURES** to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for **TINY TREASURES**.

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Administrator/Person-In-Charge)



Tuition Agreement

- I understand that my registration fee is non-refundable.
- I understand that my child's tuition is based on the spot and not the attendance.
- I understand that if my child is absent my fee remains the same unless I have officially withdrawn my child.
- I understand that an official withdrawal requires a two-week notice.
- Payment is due each Monday by 6:00 p.m. failure to pay by 12:00 p.m. on Tuesday will result in a \$20.00 late fee per child and suspension beginning at the end of the day if weekly payment is not resolved.
- I understand that after I have received one (1) returned check fee, I will no longer be able to pay with a check. There is a \$45 fee for each returned check.
- I understand that a fee of \$5 per child will be assessed every 15 minutes that I am late for pick up.

My Weekly Amount: \$_____

Registration Fee: \$115.00_____

Late Fee: \$20.00_____

Returned Check Fee: \$45.00_____

By signing I am acknowledging that I understand and agree to all fees and rates.

Parent Signature: _____

Date_____

Director/Administrator Signature: _____

Date_____