

POSH Kids Development Center  
Program name

30055082  
K8

12/11/2024  
Date

### Child Information

Child's name

Gender

Date of birth

Home street address

City

Oklahoma  
State

Mailing address

City

Oklahoma  
State

Finding directions

ZIP

County

Parent or guardian name, adult **whom child lives with**

Phone

Alternate phone

Place of employment

Business phone

Email

Parent or guardian name, adult **whom child lives with**

Phone

Alternate phone

Place of employment

Business phone

Email



### Emergency Contact

List individuals to notify, in case of emergency, when the parent or guardian cannot be reached. List in order of preference:

Name	Phone

## Immunization Record

Attach a copy of the child's immunization record. An immunization record or exemption is obtained prior to the first day of attendance and is to be updated when the child receives additional vaccines. **Parent/guardian must provide a copy of the current updated immunization record to the child care program.** Refer to Appendix II, Immunizations, in Requirements for Child Care Programs for immunization and exemption procedures.

## Health Record

Child's physician or clinic			Phone
Street address		City	State
		Oklahoma	ZIP

☐ I understand that a signed parent/guardian permission is obtained prior to administration of any medication to any child.

Does your child have any specific needs involving routine care, behavior modification, communication, eating, or sleeping activities? When yes, describe:

Does your child have any known allergies? ☐ Yes ☐ No

When yes, list:

Does the known allergy require special precautions, actions, or medications? ☐ Yes ☐ No

When yes, describe:

Describe any special precautions for diet, medication, or activity, when applicable:

Are there any other special considerations that would assist this program in providing care to your child? When yes, describe:

Will your child receive any specialized services from professionals outside of this program's personnel? ☐ Yes ☐ No

☐ When yes, I understand that a signed and dated parent permission is required.

I give permission for program personnel to consult with specialized personnel regarding the needs of my child? ☐ Yes ☐ No

## Transportation

- ☐ I **do not** give permission to transport my child.
- ☐ I give permission for my child to be transported by this program under the following circumstances:

Select all that apply:

- ☐ When an emergency occurs and I cannot be reached
- ☐ Field trips
- ☐ To and from home

Drop-off time: \_\_\_\_\_ Pick-up time: \_\_\_\_\_

Specific plan for transfer and supervision:

- ☐ To and from home

Drop-off time: \_\_\_\_\_ Pick-up time: \_\_\_\_\_

Specific plan for transfer and supervision:

- ☐ Other, specify:

## Pick Up Permission

Individuals who have permission to pick up my child:

Name	Phone

## Signature

I understand this form is supplied by the Oklahoma Human Services (OKDHS) for the convenience of the child care program and me to assist with care of my child. Supplying this form in no way imposes any responsibility or obligation upon OKDHS.

Program policies are provided to parents upon enrollment and when revisions are made.

Selecting Quality Child Care - A Parent Guide, DHS publication 87-91, Licensing Requirements for Child Care Programs, DHS publication 14-05, and the program compliance file are all made accessible to parents in a prominent location.

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

## Child Care Program Use

Date child entered program: \_\_\_\_\_

Date child withdrawn: \_\_\_\_\_

**Program Information**

POSH Kids Development Center		K8 30055082	
Program name		License number	
210 NE 38th Terrace, Suite C	Oklahoma City	OK	73105
Street address	City	State	ZIP code
210 NE 38th Terrace, Suite C, Oklahoma City, 73105			
Mailing address			
405-673-3363	Chantelle Burton		
Phone	Owner		

**Child Information**

Please list the name(s) and birth date(s) for any child(ren) you are enrolling in this program:

Name	Date of birth

**Agreement and Signature**

- I understand and am aware this program:
  - ☒ does not maintain general liability insurance coverage, as defined by Section 707 of Title 36 of the Oklahoma Statutes, of at least two-hundred-thousand dollars (\$200,000) for each occurrence of negligence. This insurance would cover injury to a child due to negligence that occurs while the child is in the care of the child care program.
  - ☐ reports self-insurance in accordance with state law.
  - ☒ is required to post **Form 07LC093E, Insurance Exception Notification** in a conspicuous location.
    - ☐ Select for a copy of **Form 07LC093E, Insurance Exception Notification** which is to be provided to parents upon enrollment or when information changes.
- This form is to be completed:
  - ☒ upon child enrollment; and
  - ☒ every 12 months thereafter.

Parent or legal guardian name	Parent or legal guardian signature	Date
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### Program Information

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210 NE 38th Terrace, Suite C	Oklahoma City	OK	73105
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Mailing address			
405-673-3363	Chantelle Burton		
Phone	Owner		

### Child Information

Please list the name(s) and birth date(s) for any child(ren) you are enrolling in this program:

Name	Date of birth

### Agreement and Signature

• I understand and am aware:

- ☐ this program is required to maintain a copy of the compliance file on-site and the information contained in the file is available for inspection.
- ☐ of the Compliance File location and its contents.
- ☐ this form is to be completed:
  - ☐ upon child enrollment; and
  - ☐ every 12 months thereafter.
- ☐ a copy of the program specific **Notice to Parents** is to be provided to parent(s) or legal guardian(s) upon enrollment.

For program specific information contained in the Notice to Parents, select one:

- ☐ DHS Publication No. 14-01, Notice to Parents for Child Care Program
- ☐ Form 07LC084E, Notice to Parents for Family Child Care Home

Parent or legal guardian name	Parent or legal guardian signature	Date
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# Enrollment Agreement

# POSH KIDS' DEVELOPMENT CENTER

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 pickup.]									
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 \_\_\_\_\_

<b>Medical Information</b>					
Child's name	Birth date	Height	Weight	Hair color	Eye color
Distinguishing marks					
<b>Child's Medical &amp; Developmental History</b>					
1. Does your child have any special medical conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
2. Does your child have any chronic illnesses? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
3. Please list a brief history of your child's serious injuries and hospitalizations. _____					
4. Does your child have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
5. Does your child have asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
6. Will medication be administered regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach care instructions from your physician.</i>					
7. Does your child have any special dietary needs? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
8. Is your child able to fully participate in all activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____					
9. Does your child have any physical restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
10. Does your child function at the level of other children in his/her age group? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____					
11. Is your child able to walk? <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. Can your child communicate his/her needs? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. Does your child need assistance at meal time? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
14. Does your child rest during the day? <input type="checkbox"/> No <input type="checkbox"/> Yes					
15. Is your child toilet trained? <input type="checkbox"/> No <input type="checkbox"/> Yes					
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____					
<b>Illness History (please check all that apply)</b>					
<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	
<i>Please attach care instructions from your physician for any of these illnesses.</i>					
<b>Disease History (please check all that apply and add the date)</b>					
<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 _____	
<b>Allergies (please list)</b>					
<b>Medication Allergies</b>		<b>Food Allergies</b>		<b>Reaction</b>	
_____		_____		_____	
<b>Bee Stings Allergies</b>		<b>Respiratory Allergies</b>		<b>Reaction</b>	
_____		_____		_____	
<b>Other Allergies</b>		<b>Are any of these allergies life-threatening?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
_____		_____			
<i>Please attach care instructions from your physician for any life-threatening allergies.</i>					
<b>Miscellaneous Screenings and Tests (please check all that apply and add the date of last screening)</b>					
<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 \_\_\_\_\_



**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
Preferred hospital/clinic for emergency care	City	State
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State

**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. Immunizations in bold are required by our state. [Check with your state requirements. You may do this at <http://www.immunize.org/states/> Bold any immunization below that is a requirement.]

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 <i>Child Emergency Contact and Release</i> .	

**Emergency Medical Authorization & Consent**

In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , 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 local hospital 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 <input type="checkbox"/> sunscreen and <input type="checkbox"/> 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 <input type="checkbox"/> have <input type="checkbox"/> do not have special instructions for the application process.	

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

**Rate Agreement and Contract**

Child's name

Birth date

**Hours of Operation**

Regular operating hours are **7:00 AM – 5:00 PM** 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 via Bright Wheel and through email. 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					

**Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)**

- Starting on \_\_\_\_\_ a fee of \$ \_\_\_\_\_ is due

- ☐ Monthly on the first of each month  
☐ Bi-Weekly

Initial

- First payment total \$ \_\_\_\_\_

- Tuition/Copays due and payable by 9 AM

- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absence other than hospitalization, 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/copay in advance of services rendered.

- I agree to pay the full tuition/copay fee even if my child is absent for one or more days.

- A late fee of \$50 is due if tuition/copay is not received on time.

- A non-refundable child enrollment fee of **\$50 or \$100 per family** is due yearly.

- A late pick-up fee of \$5 per minute per child (not to exceed \$100 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 \$35. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status.

- A 4-week written notice is required for any child being withdrawn from the program.

- A receipt for income tax purposes ☐ will ☐ will not 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 \_\_\_\_\_

**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