PRESCHOOL CONTRACT

Child's Name: _____ **Parent's Name: _____**

Child's Birth Date: _____ **Child's Current Age: _____**

The undersigned agrees to purchase care from Every Child is Special for the School Year _____. **Initials**
During the duration of the contract, space will be reserved for the child of the undersigned. Credits will not be issued for center closure due to weather conditions. The patron must understand that in the event of absences during program hours and activities, **they will be responsible for time reserved, not actual time spent at the program.** Patrons no longer requiring the Preschool Program and wishing to remove their child must notify us via email or in writing by the *15th of the month* before your drop date! _____

I have the option to pay on the 1st or the 1st and 15th using our auto-pay system through the childcare manager. I am aware that payment does include a healthy snack and all activity supplies for my child. _____

- **Auto Payments on _____ 1st OR _____ 1st and 15th**

I have the responsibility to call the facility if my child will not be attending the program _____

- **My child is fully toilet trained. YES: _____ NO: _____**

I am aware that if my child is not signed out by 11:00 AM for the morning session, a $5.00 charge will be levied for every five minutes thereafter; for example, at 11:05 AM there will be a $5.00 late charge. If, within 30 minutes, your child is not picked up and you and your emergency contacts cannot be reached, we will contact Child Care Services. We expect that your child will arrive on time as it is very disruptive to the rest of the class when arriving late. _____

I am aware not bring my child to the preschool program if he/she is ill, has a contagious condition, has been on antibiotics for less than 24 hours, or has diarrhea, vomiting, a fever of 101° or higher, an eye infection, rash with fever or severe itching, lice or nits, discharge from the eye or ears, colored discharge from the nose, or any other symptom that indicates illness or potentially contagious condition. A child who is brought to the program with any of these conditions or symptoms cannot be admitted. If any of these symptoms develop after a child has been admitted to the program, the parent will be called and informed of their child's symptoms and arrangements will need to be made to pick up child. _____

- **My child needs a: BOOSTER SEAT: _____ FULL HARNESS SEAT: _____ NO SEAT: _____**

I, guardian of the below listed registrant, a minor, agree that the registrant and I will abide by the rules of the Preschool Program. I recognize the possibility of physical injury and in consideration of Every Child is Special Preschool Program by accepting my child into the program. I hereby release, discharge and/or otherwise indemnify their employees and associate personnel (volunteers) including the owners of the facilities/equipment utilized for the program, against any claim by or on behalf of the registrant as a result of my child participating in the program and/or being transported to and from the same. _____

My Child can start on: _____ (date)

MONDAY TO FRIDAY 8AM - 11AM:_____
MONDAY TO FRIDAY 8AM – 6 PM:_____

I (Full Name): _____ agree to contract care to Every Child is Special Preschool Program for _____ (child's name**). *I understand the terms of the above agreement. I have read and understood the non-admittance due to illness policy.***

Signature: _____ Date: _____

** Every Child is Special EAST Location Enrollment Forms **

Return All Completed Enrollment Forms to:

Every Child is Special Business Office

4703 South Canyon Rd Rapid City, SD 57702

(605) 721-3770

Immunization Records must be turned in with Enrollment Forms

Family Information

Last Name	First Name	MI	Last Name	First Name	MI

Relationship to Child	Relationship to Child

Street Address	Street Address

Apartment/Unit	Apartment/Unit

City	State	Zip Code	City	State	Zip Code

Home Phone	Work Phone	Ext.	Home Phone	Work Phone	Ext.

Cell Phone	Email Address	Cell Phone	Email Address

Child Information

Last Name	First Name	MI	Last Name	First Name	MI

Sex	Date of Birth	Sex	Date of Birth

Emergency Contact	Emergency Phone	Emergency Contact	Emergency Phone

Dentist	Dentist Phone	Dentist	Dentist Phone

Doctor	Doctor Phone	Doctor	Doctor Phone

Insurance Provider	Policy Number	Insurance Provider	Policy Number

Known Allergies	Known Allergies

Emergency Care Authorization

I certify that I am a parent or legal guardian of the child or children named above and give consent for emergency medical care, surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that, time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such a case. I hereby assume all financial responsibility for such actions taken on the behalf of my child.

Parent / Legal Guardian's Signature Date

OFFICE USE ONLY

Tuition: $ _____ **Classroom:** _____ **Enrolled:** _____

Billing Cycle: _____ **Program:** _____ **Enrolled by:** _____

** Every Child is Special EAST Location Enrollment Forms **

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Every Child is Special Business Office
4703 South Canyon Rd Rapid City, SD 57702

CHILD INFORMATION SHEET

Dear Parents,

To understand the needs and provide essential services for your child, we ask that each piece of information below is answered honestly. Information provided will be kept in an individual folder for the classroom teacher's reference. Rest assured that all information will be treated with confidentiality. Please feel free to update this file as often as needed.

PROFILE

Child's Full name: _____ Would Like to be called: _____
Place of Birth: _____ Date of Birth: _____
Gender: _____ Adopted: Yes ( ) No ( )_____
Address: _____
Birth Rank: Only Child ( ) 1st ( ) 2nd ( ) 3rd ( ) 4th ( ) 5th ( ) 6th ( ) other: _____

FAMILY INFORMATION

Fathers Name: _____
Mothers Name: _____
Sibling(s) Name(s): Arrange according to birth order

Parents Divorced?
Yes ( ) No ( )

1. _____
2 _____
3. _____
4. _____
5. _____
6. _____

HEALTH & SOCIAL INFORMATION

Food/ Medication Allergies: _____
(Doctors note must be provided for us to eliminate/substitute served meals for your kid)

Health Concerns we need to know: _____
_____

Any Known Fears/ concerns we need to know: _____
_____

Hobbies/ Extracurricular Activities: _____
_____

AUTHORIZATION

I hereby authorize Staff members of Every Child is Special to apply sunscreen only to the child's face. The child and their partner will be responsible for applying sunscreen on the rest of the body under the staff's supervision. If my child is under 5 y/o, two staff will be present for the administration. Yes ( ) No ( )

I hereby Authorize Every child is Special to use pictures/ photos of my child to be used for any type of marketing in their program. Yes ( ) No ( )

_____
Signature & Date

**** Every Child is Special EAST Location Enrollment Forms ****

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4703 South Canyon Rd Rapid City, SD 57702

AUTHORIZATION RELEASE FORM

Please complete the following information authorizing the following individuals to pick-up your child from the Every Child is Special Program.

I, (Parent/ Guardian's Name): _____, authorize the following list of individuals to drop off and/or pick up my child (Child's Name): _____, to/from Every child is Special program.

Name: _____ Relationship to Child: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____

Alternate Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____

Alternate Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____

Alternate Phone: (_____) _____ Cell Phone: (_____) _____

I understand that they must *be informed* to **present** a valid photo for identification when picking up/ dropping off my child.

Signature of Parent/Guardian: _____ Date: _____

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4703 South Canyon Rd Rapid City, SD 57702

CREDIT CARD AUTOPAY AUTHORIZATION

Type of card

☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date (MM/YY)

☐☐ / ☐☐

3-Digit Code on Back

☐☐☐

Street Address and Zip Code

____

Cardholder's Name as it appears on the card

____

By signing below, I allow Every Child is Special, LLC to automatically charge my account for any balance due for services that have not been paid by the close of business on the second business day of each week or the second business day after the start of the fee period (1st or 15th of the month during the school year).

___________________________________ ___________________________________

Signature Date

Return All Completed Enrollment Forms to:
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4703 South Canyon Rd Rapid City, SD 57702

MEDICATION ADMINISTRATION CONSENT

I_____, the parent/guardian of _____ give permission to the Every Child is Special Staff to administer the following medication(s) to my child.

Medication Name: _____ Dosage/ Formulation: _____

Medication Administer Amount: _____

Parent/Guardian Signature_____ Date: _____

The below box must be initialed and dated by the parent each day the child needs medication administered to them. Kindly remember:

1. Without the parents' initials, medication cannot be given.
2. Please keep in mind that we will not accept unlabeled medications.
3. Our staff has the right to refuse medication administration when prescriptions are not provided.

		Date & Time						
Week 1								
	Parent Initials							
	Employee Initials							

		Date & Time						
Week 2								
	Parent Initials							
	Employee Initials							

		Date & Time						
Week 3								
	Parent Initials							
	Employee Initials							

		Date & Time						
Week 4								
	Parent Initials							
	Employee Initials							