



LITTLE BLESSINGS

CHILDCARE & PRESCHOOL

Student Registration Master Card:

Child's Name: _____ Sex: _____ DOB: ___/___/___

| | Parent/ Guardian | Parent/ Guardian |
|----------------------------|------------------|------------------|
| Name | | |
| Address | | |
| Social Security Number | | |
| Employer | | |
| Cell Phone | | |
| Work Phone | | |
| Home Phone (If Applicable) | | |
| Email Address | | |

Person Whom Child Lives with: _____

Child's Doctor: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Individuals to contact in case of emergency:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Does your Child have any food allergies? No/Yes: _____

Does your child have any other allergies? No/Yes: _____

Does your child have any dietary restrictions? No/Yes: _____

My Child has permission to be released with the following individuals, childcare facilities, or transportation services in addition to emergency contact persons listed about. (Please notify these individuals that they will be asked to show proof of identity before picking up child.)

| Name & Relationship | Phone Number |
|---------------------|--------------|
| | |
| | |
| | |
| | |

List additional Authorized Individuals on Back of Master Card

I authorize the facility to secure emergency medical treatment for my child.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____

Administration use only:

Date of Admission: ___/___/___ Date of Release ___/___/___

Emergency Medical Consent and Contact Release Form

***This form is to be completed and signed by child's parent/legal guardian

Child's Name _____

In the event that the child named above is injured or ill, I understand that the caregiver will attempt to contact me, the other parent, or legal guardian and the telephone numbers provided below.

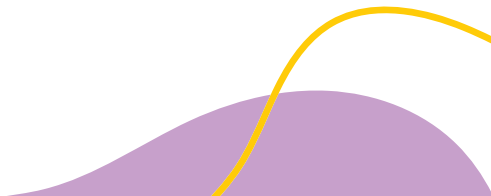
| | Parent/Guardian | Parent/Guardian |
|------------|-----------------|-----------------|
| Name | | |
| Cell Phone | | |
| Work Phone | | |
| Home Phone | | |

In the event that I or others listed are not available, I give permission to Little Blessings Childcare and Preschool to provide first aid for the child named above and to take the appropriate measures including contacting the above named and contacting the emergency medical services (EMS) system and arranging for transportation to _____ or the nearest medical facility.
(Name of Preferred Hospital)

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



Authorization for the Application of Topical Products:

Child's Name: _____

I give permission for Little Blessings Childcare and Preschool staff to apply the following topical products to my child whether center provided or parent provided:

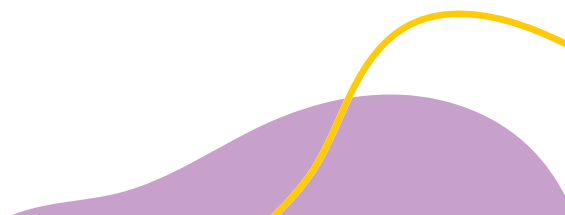
- | Yes | No | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sunscreen |
| <input type="checkbox"/> | <input type="checkbox"/> | Insect Repellent |
| <input type="checkbox"/> | <input type="checkbox"/> | Diaper Rash Ointment |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

This one time authorization will remain in effect until a new authorization is signed.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



Permission to Release Photograph

Child's Name: _____

I give permission for Little Blessings Childcare and Preschool to take photographs while at school or on field trips for the following:

_____ Classroom Projects

Initial

_____ Take home artwork and gifts

Initial

_____ School Pictures

Initial

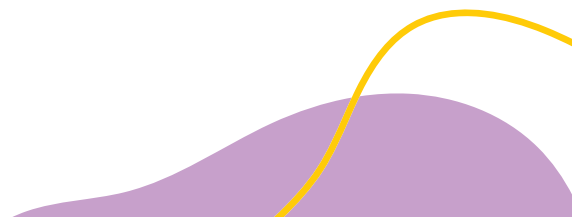
_____ Little Blessings Social Media and Website to share with parents activities

Initial and events year-round.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



Payment Contract

Child's Name: _____

I, _____ understand that Little Blessings Childcare and Preschool payment policy is as follows:

The first half of the month's tuition is due on the specified date that you have chosen above every month. If this payment is not made within three days of the date you chose there is a \$25.00 late fee added to the account. If the first half of the month's payment is not made by the 10th of the month then your account will be suspended and your child will not be allowed to be in attendance after this date. If the full month's tuition including late fees and an additional \$25.00 reinstatement fee is not paid by the 15th of the month your spot will be forfeited.

The second half of the month's tuition is due on the specified date that you have chosen every month. If this payment is not made within three days of the date you chose there will be an additional \$25.00 late fee added to the account. If the payment is not made in full by the 20th of the month then your account will be suspended and your child will not be allowed to be in attendance following this date. If the account is not cleared by the 25th of the month including late fees and an additional \$25.00 reinstatement fee, then your spot will be forfeited.

A \$35.00 NSF Fee will be added to all checks returned unpaid.

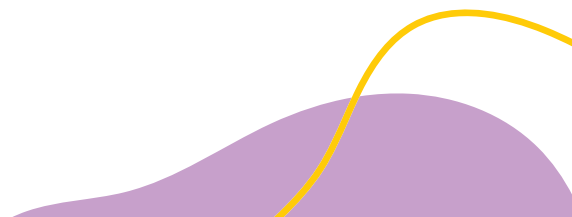
If a spot is forfeited and you would like to re-enroll your child at a future date then your payment policy will change to be a full month's tuition is due at the first of the month, and an account not paid on the first of the month will result in your spot automatically being forfeited.

If you have any additional questions, please do not hesitate to ask.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



Child Care Assistance Contract

Child's Name: _____

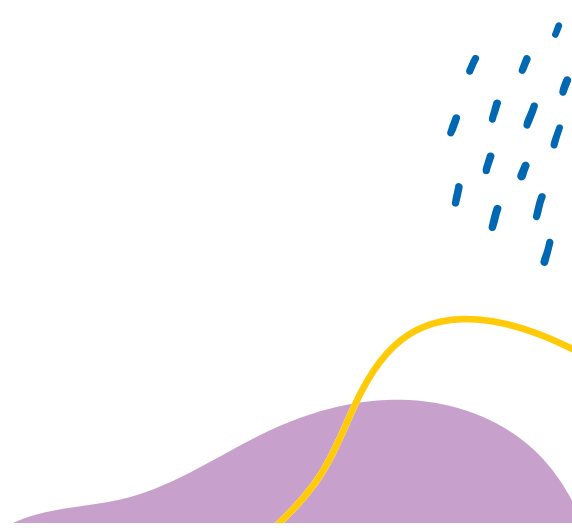
I, _____, understand the following:

If I am part of the Child Care Assistance Program, I understand that the program only pays for five missed days per month. Therefore if my child does not attend, or if I fail to sign my child in on the fingerprinting machine for more than five days in a month long period, I understand that I am responsible for any additional payments incurred as a result. This cost will be invoiced to me and I understand if not cleared up with my monthly payment then I will forfeit my spot, resulting in being reported to the child care assistance program with unpaid balance.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



By Signing Below, I agree that I have been given and fully understand the following policies:

_____ I have received a copy of the Little Blessings Childcare and Preschool
Initial Parent Handbook. I have thoroughly read and understand my handbook that includes
policies such as fees, two weeks' notice of withdrawal, \$1.00 per minute per child late pick up fee
after 5:30 pm, and student drop offs are not allowed after 9:00 A.M. without a doctor's excuse.
Doctor's excuses will not be accepted after 12:00pm.

_____ If late pick up occurs three times in a three month period the child(ren) will be suspended
Initial from care for three days, and upon the next occurrence the child will be released from care.

_____ I have been given a center tour and a pre-enrollment orientation.
Initial

_____ I have been given a copy of the behavior management policy.
Initial

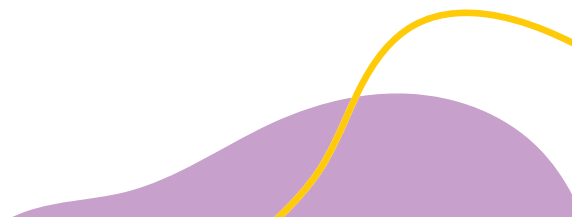
_____ I have been given a copy of the non-discrimination policy.
Initial

_____ I have been given a copy of the emergency/ evacuation procedures.
Initial

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



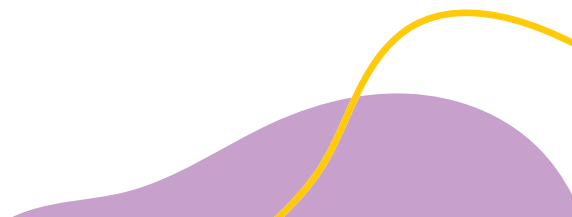
Items to bring for the 1st day of school

Infant:

- Four-Five Pre-made Labeled bottles with lid
- Pack of diapers
- Pack of wipes
- A box of Kleenex
- Extra bibs (if applicable)
- Two sets of change of clothes
- Current Immunization Records
- Copy of Birth Certificate

Toddler/Pre-K:

- Labeled blanket for naptime (sent home on Fridays to be washed)
- Pack of diapers/Pull-ups (if applicable)
- Two sets of change of clothes
- Pack of wipes
- A box of Kleenex
- Current Immunization Records
- Copy of Birth Certificate



Permission to Post Allergies

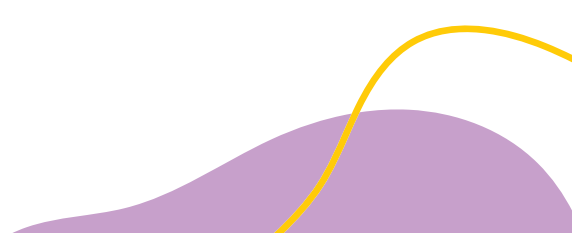
I _____ give Little Blessings Childcare and Preschool permission to post my child _____ Allergy/Allergies in the classroom where it will be visible to others.

Child's Allergy/Allergies: _____

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____



EFT Authorization Form

I hereby authorize Little Blessings Childcare and Preschool

Childs Name: _____

To make my periodic payment on my behalf from the checking or credit account listed below and transfer it to Little Blessings Child Care and Preschool.

Date to Pull Money- 3rd and 7th of Each Month

_____ Please check here if you would like whole amount pulled on first half

___ Checking Account Transfer /Check

(Account Number)

(Name on Account)

(Routing Number)

(Account Holder Phone Number)

(Bank Name)

*You can choose to give a voided check to keep in the safe.

___ Credit Card Charge

___ Visa ___ AMEX ___ MasterCard ___ Discover

(Credit Card Number)

(Expiration Date)

(CVV Number)

(First Name)

(Street Address)

(Last Name)

(City, State, Zip)

(Phone Number)

I understand that I am in full control of my payment and if at any time I decide to make any changes or discontinue this service, I will notify Little Blessings Child Care and Preschool. Change of Payment will not affect the terms of my contract.

Parents/ Guardian Printed Name _____

Date _____

Parent/ Guardian Signature _____

Welcome to the Little Blessings family! We would like to remind you that children must be signed in and out daily. Below is a list of all people that you have authorized Little Blessings to release your child to. Please notify each pick up person that they will be asked for ID if they are not recognized by a staff member. You may update this list anytime it is needed by speaking to someone in the office. If you have any questions or concerns, please let us know. Thank you!

Child: _____

Name: _____

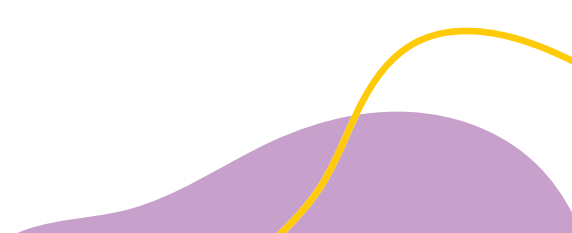
Name: _____

Name: _____

Name: _____

Name: _____

Name: _____



video Surveillance Policy

Safety and security of our children, visitors, and staff remains our highest concern at Little Blessings. To further this high priority, Little Blessings uses 24-hour video surveillance with audio. Security cameras are appropriately positioned in all classrooms, common areas, outdoor play areas, and parking lots to protect our children and staff against harm.

Because we respect the privacy of our children, families, and staff, video surveillance will be reserved for viewing purposes only, and only Directors and Assistant Directors shall have access to live surveillance. Parents or other representatives of our families will not have access to surveillance records unless an emergent situation arises requiring viewing of past video, in which case a request may be submitted to home office describing the emergency. When a request is submitted, only home office staff will have access for viewing the requested footage and will notify parents of their findings pertaining to the situation in question.

Video surveillance will only be released to city, state, or federal agencies who provide identification and the proper documentation for the footage being requested.

We appreciate your understanding and cooperation as we strive to provide a safe environment and protect the privacy of the children and families we serve.

By signing below, I, _____, am acknowledging acceptance of the Video Surveillance Policy.

Printed Name: _____

Authorized Signature: _____ Date: _____

