Enrollment Information Form

Your Child's Full Name _____ Sex ☐ M ☐ F

Name Child is Called _____ Birth Date _____

Race ☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic

☐ Asian/Pacific Islander ☐ American Indian ☐ Multiracial

Physical Address _____ Home Ph. _____

Mailing Address *(if different)* _____

Mother's Name		Father's Name	
Address *(if different)*		Address *(if different)*	
Home Phone		Home Phone	
Employer		Employer	
Occupation		Occupation	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
Cell Phone Provider		Cell Phone Provider	
Email address		Email address	

Emergency Contacts if parent can't be reached:

Name _____ Name _____

Phone _____ Phone _____

Persons Approved to Pick Up Your Child (other than parents) _____

Child's Physician and phone number _____

Does your child have any allergies or physical/social limitations that we should be aware of? _____

List brothers and sisters of your child, if any, and their ages _____

Are there others living in the home? ☐ Yes ☐ No

Are there pets? What kind and name? ☐ Yes ☐ No _____

Does the family belong to a church? ☐ Yes ☐ No If yes, where? _____

Has the child attended preschool? ☐ Yes ☐ No If yes, where? _____

Parent's Signature _____ Date _____

Class in which you are registering your child: **2 Year-Olds** ☐ 2-day ☐ 3-day 2 day= T, TH 3 day= M,W,F

Age of child as of September 1st of this year *(must be 2 by September 1st of this year)* _____

Date received _____ Check #/Cash _____ Amt $_____ Confirmation Date _____

☐ Copy of Birth Certificate

☐ Copy of Authorization for EMT

☐ Copy of Blue & Yellow Health Forms

☐ Photo Release

☐ $100 Registration Fee

☐ $150 Supply Fee

New Hope Early Learning, 120 N. Knights Avenue, Brandon FL 33510

813-689-9482 wendy@brandonchurch.com

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____ should become ill or injured at New Hope Early Learning, I understand that the facility will: (1) Contact me immediately and (2) contact the person(s) I have designated if I cannot be reached. Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate emergency medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

Signature: _____ Relationship:_____
Date: _____

Medical Alert Information (i.e. allergies, medical and/or handicapping conditions):

_____
_____
_____

Preferred Physician_____ Preferred Hospital: _____
Address of Physician:_____ Phone:_____

MEDIA RELEASE

I, the undersigned, do hereby grant permission to New Hope Early Learning to use the image of my child. Such use includes the display, distribution, publication, transmission, or otherwise use of photography, images, and/or video take of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the New Hope website.

☐ **Deny** permission to use my child's image at all. Please be advised that some photos and videos are taken as part of craft projects.

_____ Date: _____
Parent/Guardian Signature

VERIFICATION OF PARENT'S RECELIVING REQUIRED DOCUMENTS

Please initial each line noting that you were given these documents.

_____ KNOW YOUR CHILD'S DAY CARE CENTER

_____ BEHAVIORAL GUILDELINES AND DISCIPLINARY PRACTICES

_____ INFLUENZA VIRUS, THE FLU, A GUIDE TO PARENTS

_____ GETTING IN; GETTING OUT

_____ ALTERNATE NUTRITION AGREEMENT (You will provide lunch.)

New Hope Early Learning

2019-2020 Child's Name: _____

Before Care Rates

Cost Per Month

Number of Days per Week

	1	2	3	4	5
7:00 - 9:00	$25	$50	$75	$100	$120

	Monday	Tuesday	Wed.	Thurs.	Friday
Day choice:					

After Care Rates

Cost Per Month

Number of Days per Week

	1	2	3	4	5
12:30 - 1:30	$25	$40	$60	$80	$100
12:30 - 6:00	$70	$135	$200	$265	$310

___ 12:30 - 1:30 ___ 12:30 - 6:00

	Monday	Tuesday	Wed.	Thurs.	Friday
Day choice:					

Tuition

	Days	T, TH	M,W,F	M,W,F		
	Due	2's/2day	2's/3day	3's/3day	3's/5 day	Kindergarten
Registration Fee	At Reg.	100	100	100	100	100
Supply Fee	1-Aug	150	150	150	150	150
Aug Tuition	First day	210	250	210	230	230
Sept. - May	Monthly	210	250	210	230	230

Extended Rate	VPK
Due at sign up	60
Monthly	
payment	
Sept-May	60

Before care cost:	$
After care cost:	$
Monthly Tuition	$
TOTAL MONTHLY COST:	$

I have read and understand the following information:

1 Registration fee is non-refundable.
2 Tuition, before care, and after care are due on the first of the month.
3 Accounts paid after the first of the month will be charged $25.
4 There will be a $30 fee for any returned checks.
5 Parent must provide child with an afternoon snack and drink.
6 If you are late to pick-up your child, late fees will be added as stated below:
    1st Time: $10 fee **plus** $1 per minute.
    2nd Time: $25 fee **plus** $1 per minute.
    3rd Time: $35 fee **plus** $1 per minute. Child can no longer attend.
7 No reimbursement for days not used or holidays.

Date: _____ Signature: _____