

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	_____
Address (if different)	_____
Home Phone	_____
Employer	_____
Occupation	_____
Work Phone	_____
Cell Phone	_____
Cell Phone Provider	_____
Email address	_____

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

Emergency Contacts if parent can't be reached:

Name _____
Phone _____

Name _____
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:

VPK 5-day

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 _____

- | | |
|---|---|
| <input type="checkbox"/> Copy of Birth Certificate | <input type="checkbox"/> Photo Release |
| <input type="checkbox"/> Copy of Authorization for EMT | <input type="checkbox"/> \$100 Registration Fee |
| <input type="checkbox"/> Copy of Blue & Yellow Health Forms | <input type="checkbox"/> \$150 Supply Fee |

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.

Parent/Guardian Signature Date: _____

VERIFICATION OF PARENT'S RECEIVING REQUIRED DOCUMENTS

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

- _____ KNOW YOUR CHILD'S DAY CARE CENTER
- _____ BEHAVIORAL GUIDELINES 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

Day choice:

Monday	Tuesday	Wed.	Thurs.	Friday

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

Day choice:

Monday	Tuesday	Wed.	Thurs.	Friday

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	Extended Rate	VPK
Registration Fee	At Reg.	100	100	100	100	100	Due at sign up	60
Supply Fee	1-Aug	150	150	150	150	150	Monthly	
Aug Tuition	First day	210	250	210	230	230	payment	
Sept. - May	Monthly	210	250	210	230	230	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: _____