Enrollment Agreement

K-6 After School Enrichment Program

Completion of this agreement is required for enrollment in the Town of Stratford: K-6 After School Enrichment Program. 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 of Connecticut, Office of Early Childhood regulations for licensed childcare programs.

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? □ Yes □ No	School Name	Grade	School Phone
School Address	School Start Time	School Closing Time	

Family Information

List family members 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 make sure you list all available adults that you authorize to pick up your child. Please notify the center immediately if contact information for designated pick up / emergency contacts change at any time while your child is enrolled in our program.
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 pick up.

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 _____

Medical Information

Child's Name	Birth Date	Height	Weight	Hair Color	Eye Color

Distinguishing Marks

Child's Medical & Developmental History

1. Does your child have any special medical conditions? □ No □ Yes Explain _____
2. Does your child have any chronic illnesses? □ No □ Yes Explain _____
3. Please list a brief history of your child's serious injuries and hospitalizations. _____
4. Does your child have diabetes? □ No □ Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma? □ No □ Yes *If yes, please attach care instructions from your physician.*
6. Will medication be administered regularly? □ No □ Yes *If yes, please attach care instructions from your physician.*
7. Does your child have any special dietary needs? □ No □ Yes Explain _____
8. Is your child able to fully participate in all activities? □ Yes □ No Explain _____
9. Does your child have any physical restrictions? □ No □ Yes Explain _____
10. Does your child function at the level of other children in his/her age group? □ Yes □ No Explain _____
11. Is your child able to walk □ Yes □ No _____
12. Can your child communicate his/her needs? □ Yes □ No _____
13. Does your child need assistance at meal time? □ No □ Yes Explain _____
14. Does your child rest during the day? □ No □ Yes
15. Is your child toilet trained? □ No □ Yes
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? □ No □ Yes Explain _____
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? □ No □ Yes Explain _____
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? □ No □ Yes Explain _____

Illness History *(please check all that apply)*

□ Vision problems	□ Nosebleeds	□ Seizures
□ Hearing problems	□ Skin rashes	□ Mouth sores
□ Constipation	□ Sore throats	□ Fainting
□ Diarrhea	□ Ear infections	□ Persistent cough
□ Asthma/breathing problems	□ Urinary tract infections	□ Other

Please attach care instructions from your physician for any of these illnesses.

Disease History *(please check all that apply and add the date)*

□ Chicken Pox (Varicella)		□ Bronchiolitis		□ Botulism	
□ Measles Rubella		□ Pneumonia		□ Hemophilus Influenza	
□ Rubella (German Measles)		□ Pertussis (Whooping cough)		□ Meningococcal Infection	
□ Mumps		□ Tetanus		□ Rabies	
□ Scarlet Fever		□ Diphtheria		□ Bacterial Meningitis	

Allergies *(please list)*

Medication Allergies	Reaction	**Food** Allergies	Reaction
Bee Stings Allergies	Reaction	**Respiratory** Allergies	Reaction
Other Allergies	Reaction	**Are any of these allergies life-threatening?**	□ **Yes** □ **No**

Please attach care instructions from your physician for any life-threatening allergies.

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

□ Vision		□ Developmental		□ Tuberculosis (PPD)	
□ Hearing		□ Aptitude		□ Sickle Cell Anemia	
□ Speech		□ Educational		□ 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

Child's Medical Care Provider

Primary Physician's Name	Primary Physician's Practice Name		Phone
Physician's Practice Address	**City**	**State**	**Zip**
Preferred Hospital/Clinic for Emergency Care	**City**		**State**
Dentist's Name	**Dentist's Practice Name**		**Phone**
Dentist's Practice Address	**City**	**State**	**Zip**

Child's Insurance Provider

Child's Health Insurance Provider Name	Policy Number	Secondary Health Insurance Provider Name	Policy Number

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.
You may do this at: ct.gov/izrecord

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

	Initial
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.	
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 virus or 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 1 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.	

Emergency Medical Authorization & Consent

	Initial
In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.	
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.	

	Initial
I give my permission to this center to apply □ sunscreen and □ insect repellant to my child. *Please check which products you will permit.*	
I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	

I □ have □ 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 **Monday – Friday from 3:00pm – 6:00pm** except closings for various holidays, and inclement weather as described in the K-6 After School Enrichment Program Policy. Please make sure to keep track of the program's current calendar for holidays and program closures. 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 on South End Community Center voicemail. 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 program follows the Stratford Public Schools calendar operating from 3:00pm-6:00pm Monday – Friday. When school is closed early due to teacher days and elementary Parent/ Teacher conferences, the program operates from 1:00pm-6:00pm. When the Stratford Public Schools close early or cancels after school activities due to severe weather conditions, the K-6 ASE Program is also closed.

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

		Initial
- Starting on _____ a fee of **$**_____ is due	□ weekly. □ bi-weekly. □ monthly.	
- Tuition is due and payable by the 15th of the month or next business day		
- 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 in advance of services rendered.		
- I agree to pay the full tuition fee even if my child is absent for one or more days.		
- A late fee of $15.00 is due if tuition is not received on time by the 15th of every month.		
- A non-refundable registration fee of $60.00 is due yearly.		
- A late pick up fee of $10.00 for the first ten minutes and an additional $5.00 for every (5) minutes after per child is due if my child is not picked up before the 6:00pm closing time.		
- 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 will be charged a fee of $15.00. Two or more returned checks will result in my account being placed on "money order only" status.		
- A (2) -week written notice is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit.		
- A receipt for income tax purposes will be provided upon request.		

Other Agreements

Private Employment Acknowledgement and Release

	Initial
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.	

Media Release

	Initial
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.	

Parent initial _____ Staff initial _____ Date _____

Other Agreements *(continued)*

Child's name	Birth date

Walking Excursions

	Initial
I give my permission for my child to participate in supervised walking excursions near and around the center.	

Program Policy Acknowledgement

	Initial
I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the K-6 After School Enrichment Program Policy Handbook and agree to abide by them.	
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 K-6 After School Enrichment Program Policy 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

School Age Child Care Supplemental Enrollment Form **K-6 After School Enrichment Program**

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.

Transportation Approval

I understand that my child will be transported from _____ School by Town of Stratford – SECC van to the South End Community Center located at 19 Bates Street, Stratford, CT. I also understand that I am responsible for informing the **K-6 After School Enrichment Program** by phone or email if my child(ren) will not be in attendance to the program so that transportation is not scheduled. 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

Your child's safety is our number one priority. **K-6 After School Enrichment Program** will not release children from the program without the above information **in writing**.

Primary Parent/Guardian/Sponsor Signature _____ Date _____