Little People's Learning Center

Enrollment Form

Center Use Only
Enrollment fee paid: ___/____/_____
Immunization record: ___/____/_____
Approximate start date: ___/____/_____

Child's name:		**Nickname?**	
Due date/Date of birth:		Sex:	
Home address:		Phone:	
City, State:		Zip:	

Parent's name:		**cell phone**	
Home Address:		home ph:	
City, State:		Zip:	
Email:			
Employer		Occupation	
Work Address:		Work ph	
City, State:		Zip:	

Parent's name:		**cell phone**	
Home Address:		home ph:	
City, State:		Zip:	
Email:			
Employer		Occupation	
Work Address:		Work ph	
City, State:		Zip:	

Siblings

Name	**Age**	**Also enrolled?**

Other than the above listed parents or guardians, only the following person(s) may remove your child from care without previous written notice. For the safety of your child **PHOTO ID WILL BE REQUIRED**.

Name	**Relationship**	**Phone**

(Continued on back)

Medical Information

Emergency contact

In cases of emergency, parents or guardians will be notified as soon as possible. In the event we cannot reach a parent or guardian, who else should we contact?

Name: _____

Relationship to child: _____ Phone: _____

Parents are responsible for all costs associated with emergency medical treatments.

Healthcare Provider Information

Physician:		**Phone:**	
Dentist:		Phone:	
Other:		Phone:	

Insurance Information

Insurance Company:			
Name of Subscriber:		Plan number	

List all hospitalizations or chronic illnesses:

_____

_____

Which communicable illnesses (chicken pox; hand, foot, mouth; measles; scabies) has your child had: _____

_____

Is your child currently on medication? ☐ Yes ☐ No
if yes, name of medication(s): _____

What condition is this medication taken to treat? _____

Allergies

Type	Allergen	Reaction
Medications:		
Food(s):		
Bee stings:		
Respiratory:		
Other:		

Are any of the allergies severe or life-threatening? ☐ Yes ☐ No (If yes, please talk to your Center Director about completing an allergy plan.)

Emergency Medical Care Release

In case of an emergency, I understand that center staff will attempt to contact me immediately. I also authorize center staff to:

- Consult the physician or dentist named above.
- Administer first aid and/or cardiopulmonary resuscitation.
- Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility.
- Obtain any emergency medical, surgical or dental treatment deemed necessary by medical authorities.
- Transport my child to a local emergency shelter in the event of an emergency evacuation of the center.

_____ _____

Parent/guardian signature Date

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

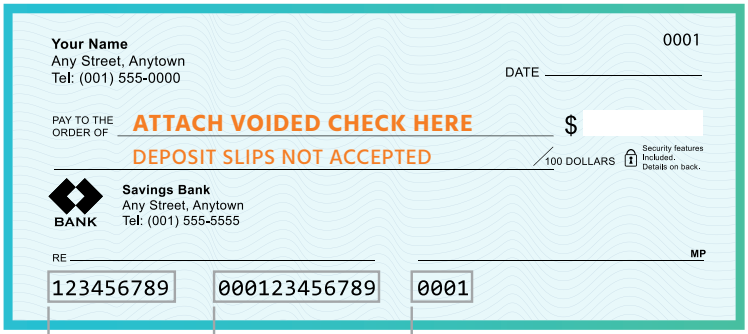
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

LPLC Agreement

I consent to the enrollment of the child listed below in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, as outlined in this handbook. I will promptly update any information provided to the center about my child's health, contact information, or other information changes. I acknowledge that a child may be dis-enrolled by the center without prior notice if, in the sole opinion of the center, it is in the best interest of the child or the center.

Financial Obligations

- As the parent/guardian signing this Enrollment Agreement all amounts due are ultimately my responsibility.
- Overdue accounts may be referred to a collection agency. I am responsible for all account balances, plus reasonable collection and attorney fees associated with the collection of the account.
- All families are required to provide a Tuition Express backup form of payment.
- I give permission for LPLC to charge this account in the event that there is an outstanding balance on my account after the due date. I can change this information at any time, but must provide at least 14 days notice of any change.
- Payments from families with prior unpaid, returned checks or multiple late payments must be in the form of automatic deposits. Families with returned payments may be subject to immediate termination of services and are responsible for any associated fees.
- Any prepaid balance of $25 or less which remains at the time of my child's dis-enrollment will not be refunded unless requested in writing within 90 days.
- Thirty days written notice is required prior to the last day of attendance. If I do not give thirty days written notice of withdrawal, I agree to pay full tuition and fees due for the final month regardless of my child's attendance.

LPLC reserves the right to alter policies and/or program at any time. The terms of this agreement, including the tuition and fees, are subject to change in whole or in part by the center with 30 days' notice.

Child's Name			
Parent Signature		Date:	

Permission Slips

I give permission for staff of Little People's Learning Center to take my child on walking field trips off the Little People's property for the 2021-2022 School Year and Summer 2022.			
Child's Name			
Parent Signature		Date:	

I give permission for Little People's Learning Center to appropriately photograph my child and share those pictures with my family and LPLC families (as in weekly updates or in invite-only photo folders)			
Child's Name			
Parent Signature		Date:	

I give permission for Little People's Learning Center to appropriately photograph my child and utilize those pictures to share on the center's website, social media accounts and in marketing materials.			
Child's Name			
Parent Signature		Date:	

I give permission for my child _____ to drink pasteurized milk:
(Please check one)

- ☐ At all meals, including snack.
- ☐ At lunch only.
- ☐ Only the milk I provide.
- ☐ No milk due to allergy.
- ☐ No milk due to preference.

Parent Signature		Date:	

This document is good for two years, but must be signed for renewal in the second year.

Parent Signature		Date:	

Little People's Learning Center

About your child

Center Use Only
Name:
Date of intake: ___/____/_____

The following information is requested to provide the best care for your child. Your responses assist us in getting to know your child, as well as allowing us to be consistent with daily routine as much as possible. All information is confidential.

Has your child been in child care before? ☐ Yes ☐ No

Does your child have experience with: ☐ Other children ☐ Siblings ☐ Adults

How does your child get along with other children? _____

Other languages spoken at home: _____

Have there been any recent changes in your family structure? (ex: a move, new sibling, marriage, divorce/separation, or death of someone close)_____

Please check the words that best describe your child:

☐ calm	☐ shy	☐ aggressive	☐ sensitive
☐ cheerful	☐ loud	☐ bright	☐ stubborn
☐ creative	☐ active	☐ hyperactive	☐ destructive
☐ curious	☐ loving	☐ refuses eye contact	☐ thoughtful
☐ gives in easily	☐ inventive	☐ happy	☐ brave
☐ shares well	☐ contented	☐ easily angered	☐ independent
☐ busy	☐ excitable	☐ on task/focused	☐ unfocussed
☐ social	☐ quiet	☐ jealous	☐ anxious

How does your child usually express his/her feelings? _____

Does your child: ☐ use a pacifier ☐ suck thumb ☐ suck fingers

What are your child's favorite activities? _____

Least favorite activities? _____

What behavior do you find most difficult to handle? _____

What method of discipline works best for your child? _____

Who enforces most of the discipline at home? _____

What frightens your child? _____

Are their "family" or "house" rules your child's caregiver should be aware of? _____

_____

Eating Habits

Favorite foods:_____ Dislikes:_____

At home, does your child eat: ☐ held in lap ☐ highchair ☐ at table ☐ other

Does your child eat unassisted using: ☐ fingers ☐ spoon ☐ fork ☐ knife

Does your child drink from: ☐ bottle ☐ sippy cup ☐ open cup

Does your child require the use of a dropper, weighted cup, or other adaptive equipment to self-feed? _____

_____

Eating habits that you are concerned with? _____

Any medical or religious dietary restrictions? _____

For Infants

Nourishment: ☐ breast milk ☐ formula ☐ combination ☐ baby foods

Any history of colic? ☐ yes ☐ no Time of day? _____

Mobility: ☐ rolls ☐ crawls ☐ "cruises"/walks with assistance ☐ walks

Example schedule:

Time	Activity
:	Wakes
:	
:	
:	
:	
:	
:	
:	
:	
:	
:	
:	

Accessibility and Accommodation

At Little People's we strive to provide the most inclusive experience possible for your child. The more that we know about the challenges and strengths your child has, the better we can help your family to meet those challenges and build on those strengths.

Is there a family history of any learning/behavioral difficulties? _____

Does your child receive therapeutic services in a developmental center or school? _____

Where? _____

If yes, please check which services:

☐ Speech therapy
☐ Occupational Therapy
☐ Physical therapy
☐ Psychological/Counseling services
☐ Behavioral therapy
☐ Art therapy

Mobility Support (check all that apply)

☐ does not move self
☐ uses walker
☐ uses cane
☐ crawls
☐ uses crutches
☐ wears adaptive shoes

Communication Support (check any that apply)

☐ wears glasses
☐ uses sign language and/or hand signals
☐ uses lightboard or other adaptive devices
☐ wears hearing aids
☐ lip reads

I give permission for my child to participate in early learning assessments and health screenings administered by LPLC. The results of these assessments will be used by LPLC to measure my child's progress and to identify any health issues. I will have access to all results of these assessments.

_____ _____

Parent/guardian signature Date

OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

****

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

☐ Diaper Rash Cream/Ointments

☐ Insect Repellent

☐ Sunscreen

☐ Cortisone/Anti-Itch Creams/Ointments

☐ Medicated Lip Treatments

☐ OTC Antibiotic Creams/Ointments

☐ Teething Tablets/Ointments

☐ Burn Creams/Sprays

☐ Other Non-Ingestible OTC's: (Please Specify)_____

- ☐ _____
- ☐ _____
- ☐ _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

*** This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date _____/_____/_____

***Keep in the child's file when medication is finished.**