

Enrollment Agreement:
2022-2023

Kaleidoscope of Learning Preschool
335 Byram Drive, Byram, MS 39272
(601) 502-2990

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 childcare licensing regulations.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Class/Grade		School phone	
Mandatory Drop before 9:00 a.m. daily Preschoolers must be picked up before 5:00 p.m.			Drop off time (maximum 9 hours a day) (7am-4pm) (7:30-4:30pm) (8am-5pm)		Pick-up time		

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor		Relationship to child		Home phone		Work phone		
Home address if different from above			City		State		Zip	
Contact email		Cell phone			Cell phone carrier			
Employer	Employer address		City		State		Zip	Work hours
Other parent/guardian/sponsor		Relationship to child		Home phone		Work phone		
Home address if different from above			City		State		Zip	
Contact email		Cell phone			Cell phone carrier			
Employer	Employer address		City		State		Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if a person other than the contacts listed on the Child Emergency Contact will pick up your child on a given day.
[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 pickup.]

Person #1	Relationship to child		Home phone		Cell phone		
Home address			City		State		Zip
Person #2	Relationship to child		Home phone		Cell phone		
Home address			City		State		Zip
Person #3	Relationship to child		Home phone		Cell phone		
Home address			City		State		Zip
Person #4	Relationship to child		Home phone		Cell phone		
Home address			City		State		Zip
Person #5	Relationship to child		Home phone		Cell phone		
Home address			City		State		Zip

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 or by calling the center. 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
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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 special needs or disabilities? 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. Does your child have eczema? 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 Explain _____

12. Can your child communicate his/her needs? Yes No Explain _____

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 on-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 participated in a group care setting?
 No Yes Explain _____

Illness History *(please check all that apply)*

<input type="checkbox"/> Vision problems	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sore throats	<input type="checkbox"/> Fainting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Urinary track infections	<input type="checkbox"/> Other

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

Disease History *(please check all that apply)*

<input type="checkbox"/> Chicken Pox (Varicella) _____	<input type="checkbox"/> Bronchiolitis _____	<input type="checkbox"/> Botulism _____
<input type="checkbox"/> Measles/Rubella _____	<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Haemophilus Influenza _____
<input type="checkbox"/> Rubella (German Measles) _____	<input type="checkbox"/> Pertussis (Whooping cough) _____	<input type="checkbox"/> Meningococcal Infection _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Rabies _____
<input type="checkbox"/> Scarlet Fever _____	<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____	Does your child have an Epi pen? _____	

Please attach care instructions from your physician for any life-threatening allergies or if the child has an Epi pen. Epi pin authorization form required.

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

<input type="checkbox"/> Vision _____	<input type="checkbox"/> Developmental _____	<input type="checkbox"/> Tuberculosis (PPD) _____
<input type="checkbox"/> Hearing _____	<input type="checkbox"/> Aptitude _____	<input type="checkbox"/> Sickle Cell Anemia _____
<input type="checkbox"/> Speech _____	<input type="checkbox"/> Educational _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Behavior _____		

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
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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
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Child's Immunization History (please attach a copy of your child's immunization records Form 121) New students only.

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state for requirements.]**

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

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 childcare regulations.	Initial
2. I agree to provide information to the childcare center about my child's conditions, illnesses, allergies or other needs.	_____
3. If my child becomes ill with a reportable contagious 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 childcare 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 hour after being contacted. If I cannot be reached, the staff will contact those listed in the <i>Child Emergency Contact and Release</i> .	_____

Emergency Medical Authorization & Consent

In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , and lastly my physician.	Initial
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.	_____
The center will not administer or dispense any type medicine to the children.	_____

I have received a copy of the Mississippi State Department of Health Regulations Summary for Parents. Yes No _____

I give my permission to this center to transport my child in case of an emergency or on a scheduled excursion. *Permission forms will be sent home for each excursion.* Yes No _____

My child will eat breakfast lunch snack at the center. _____

Parent initial _____ Staff initial _____ Date _____

Rate Agreement and Contract

Child's name Birth date

Hours of Operation

Preschool/Summer Camp operating hours are Monday through Friday from 7:00 AM to 5:00 PM except closings for various holidays... The procedure to notify families should severe weather or other conditions prevent the center from opening on time...

Scheduled Fees

Registration fees and curriculum fees due at the time of registration.

Table with 6 columns: Fee Name, Amount, Frequency, Tuition Infant, Tuition Toddler, Tuition 4 Year Olds, Tuition 2 Year Olds, Tuition 3 Year Olds, School Age After School, School Age Summer Camp, K5-AC Drop In.

I would prefer to make tuition payments on a bi-weekly monthly basis.

Fee Policy (to be completed and initialed by the parent/guardian/sponsor)

- Starting on a fee of \$ is due
- Tuition is due and payable on Monday every two weeks. The first business day of the month.
- Tuition is not subject to discounts for holidays, emergency closures...
- 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 \$10 is due if tuition is returned on Monday for bi-weekly and a \$20 late fee is returned after Tuesday.
- A non-refundable registration fee of \$75 is due yearly for the first child and \$25 for each additional child.
- A late pick-up fee of \$5 for the first minute and \$1 per minute afterwards per child (not to exceed \$64 per child) is due if my child is not picked up before closing.
- A written two weeks' notice is required by the center for withdrawal.
- 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.
- All returned ACH transactions (automatic debits) will be charged a fee of \$33.50. Two or more returned ACH transactions will result in my account being place on "debit card transaction only" status or termination.
-Parents will not be able to change payment option during the school year. All payments are setup on automatic bank draft.

Other Agreements

Media release

Occasionally, photos will be taken of the children at the center for use within the center or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

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

Date of Acceptance Date of Withdrawal Reason for Withdrawal

Preschool Application