Enrollment Agreement:
2025-2026

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? □ Yes □ 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) Select Hours: □ (7am-4pm) □ (7:30-4:30pm) □ (8-5)	Select Days of Service Needed: □ **(M-F)** □ **(Drop-In)**

Family Information-Please complete all sections on form. (NA)

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.] PIN# generated.

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. All persons listed will have a unique PIN# generated after registration.

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 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 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 participated 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 track infections	□ Other

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

Disease History *(please check all that apply)*

□ Chicken Pox (Varicella)		□ Bronchiolitis		□ Botulism	
□ Measles Rubella		□ Pneumonia		□ Haemophilus 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** **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)*

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

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 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

	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 childcare regulations.	
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 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.	
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. □ Yes □ No
Permission forms will be sent home for each excursion.

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, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no discount in tuition as a result of center closures or quarantines. After School hours are (3pm-6pm).

The procedure to notify families should severe weather or other conditions prevent the center from opening on time or at all you will be emailed through Procare Management App. 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 Fees

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

Toddler Curriculum	$20	Yearly		Tuition Infants-$350/$700.00	Tuition 4 Year Olds-$300.00/$600.00
K2 Curriculum	$60	Yearly		Tuition Toddler $330.00/$660.00	School Age After School-$160.00/$320.00
K3 & K4 Curriculum	$100(K3)$130(K4)	Yearly		Tuition 2 Year Olds-$330.00/$660.00	School Age Summer Camp-$270/$540
Cot Rental	$10	Yearly		Tuition 3 Year Olds-$300.00/$600.00	K5-AC Drop In-$35.00 a day (Summer Only)

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

□
□
□ ACH (Bank Draft Only)

Initial

- Tuition is due and payable on
  - □ Monday every two weeks.
  - □ The first business day of the month.

- Tuition is not subject to discounts for contagious illness, holidays, or emergency closures (i.e., weather). Absences 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 **$20** is due if tuition is returned on Monday for bi-weekly and a $20 late fee for monthly returned tuition payments.

- A non-refundable registration fee of **$100** 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 $2** 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. A specific permission slip may be required.

- 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 placed on "debit card transaction only" status or termination of service.

-Parents will not be able to change payment option during the school year. All payments are set up on automatic bank draft through the office.

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. **Initial**

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_____ **Initial**

Preschool Application