

FOR OFFICE USE: Assigned Classroom _____ FT/ MWF/ TR

Enrollment Start Date: _____

**MARY'S LITTLE LAMBS PRESCHOOL
STUDENT ENROLLMENT APPLICATION (Please print legibly)**

Child's Full Name _____ Gender: Male Female

Date of Birth _____ Age by months: _____

Home/Cell Phone # (Best contact number) _____

My child is **allergic** to _____

My child takes medication for _____ Name of medication _____

Special Needs _____

Parent/Guardian Information:

Mother's Name _____

Address: _____ Cell # _____

_____ Phone Carrier (e.g. AT&T) _____

Email: _____ Employer _____

Work Schedule/Hours: _____ Work # _____

Father's Name _____

Address: _____ Cell # _____

_____ Phone Carrier (e.g. AT&T) _____

Email: _____ Employer _____

Work Schedule/Hours: _____ Work # _____

Marital Status? _____

Custody Information _____

Names of those who are authorized to pick up your child:

1. Name _____ Home/Cell # _____ Work # _____

Relation to child _____

2. Name _____ Home/Cell # _____ Work # _____

Relation to child _____

3. Name _____ Home/Cell # _____ Work # _____

Relation to child _____

* We will ask to see a photo ID for any individual we do not recognize. A person must be at least 18 years of age to be allowed to pick up your child.

Non-Authorized Pick-up (Court Documents Required) _____

MLLP program cannot withhold a child from his/her parent without a court order. If you have custody and do not wish for your child's other parent to be allowed to pick him/her up, we must have a copy of the court order stating no contact.

EMERGENCY CONTACT INFORMATION

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

Name: _____ Home # _____

Relationship: _____ Work # _____

Address: _____ Cell/Pg. _____

No one other than the above listed names may remove a child unless I receive an emergency phone call, or I am presented with an authorization signed by the Parent/Guardian.

Parent/ Guardian Signature _____ **Date** _____

Medical Information:

Immunizations: Please provide an updated copy of your Child's Immunization Record or if your child was immunized in the State of Arkansas, we request your permission to access a copy of your child's immunization record through the Arkansas shot records database for licensed preschools.

Parent/ Guardian Signature _____ **Date** _____

Family Doctor _____ Phone # _____

Location and Address: _____

Family Dentist _____ Phone # _____

Address: _____

Insurance Company _____ Policy # _____

Authorization and permission given for:

(Please Initial)

- A. Emergency aid medical and/or dental care and transportation
Of your child for emergency treatment..... _____
- B. Administer first aid or CPR in event of emergency..... _____
- C. Parent responsible for medical costs for injuries occurred on
Mary’s Little Lambs Preschool premises..... _____
- D. Your child to participate in water activities..... _____
- E. Apply sunscreen as needed for outdoor activities..... _____

CONSENT FOR EMERGENCY MEDICAL CARE WHEN PARENTS CANNOT BE REACHED

I/We, _____, parent/guardian, of _____, do hereby request and give consent to the Director/Caregiver of Mary’s Little Lambs Preschool, or his/her duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director/Caregiver or his/her duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached. Parents will be responsible for all medical costs.

Parent/ Guardian Signature _____ **Date** _____

RELEASE OF PUBLICATION

Video or still pictures are at times part of our program and only for our program which includes our web pages, social media pages, magazines or tv, and/or classroom project activities. Your permission for pictures is requested.

I/We give permission for Mary’s Little Lambs Preschool to photograph me and/or my child and use for publicizing activities.

Parent/ Guardian Signature _____ **Date** _____

NOTE: Pictures are used for your child’s portfolios or Procure app communication. If this is the only consent for classroom activity use only, please make a notation in the provided space.

I acknowledge that I have received Mary’s Little Lambs Preschool Parent Handbook as well as a copy of the Kindergarten Readiness Indicators Checklist prepared by the Arkansas State Department. I have read and accept all policies and procedures and the enrollment conditions of Mary’s Little Lambs Preschool. I understand that I may ask for a conference with caregiver(s) as needed.

Parent/Guardian Signature _____ Date _____

PRIVATE PAYER FEE AGREEMENT (NON-VOUCHER)

(please initial)

_____ A \$100.00 non-refundable registration fee must be paid at the time your child is enrolled and reenrolled into the program. Additional fee may apply for siblings.

_____ I understand that payment is due on Friday *before* the week of service. There will be a \$10.00 late fee charge for payments made thereafter. Additional \$10.00 late fee will be assessed after each week for open balances. There is a \$15.00 fee for any returned checks or insufficient funds.

_____ There are no refunds or credits for absences, illness, or holidays. Tuition must be paid in full.

_____ I understand that there is a supply fee of \$125.00 to be paid in the first Monday of March and first Monday in September. \$100.00 for each additional child. Pro-rated supply fee is \$25.00 per month.

_____ I understand that there will be a \$5.00 charge per every 5-minute increments for early drop-off before 7:00a.m. or for late pick-up after 6:00 p.m. as according to the facility clock.

_____ I understand my child’s tuition rate and agree to pay in full for each week of service, including weeks that the center may be closed for holidays (see Parent Handbook for specific closing dates).

_____ I understand I may be charged for no full two weeks’ notice of withdrawal from the center.

In the event that I default on the above agreement and do not make a payment within two weeks, my child’s enrollment may be terminated, and I will be responsible for the costs of collection.

Parent/ Guardian Signature _____ Date _____

VOUCHER PARTICIPANT FEE AGREEMENT (If applicable)

(please initial)

_____ A \$100.00 non-refundable registration fee must be paid at the time your child is enrolled or reenrolled into the program. Additional fee may apply for siblings.

_____ I understand that payment is due on Friday before the week of service. There will be a \$10.00 late fee charge for payments made thereafter. Additional \$10.00 late fee will be assessed after each week for open balances. There is a \$15.00 fee for any returned checks or insufficient funds.

_____ There are no refunds or credits for absences, illness, or holidays. Tuition must be paid in full.

_____ I understand that there is a supply fee of \$50.00 to be paid on the first Monday of March and first Monday in September. \$40.00 for each additional child. This fee does not apply to Foster care or TEA programs.

_____ I understand that there will be a \$5.00 charge per every 5-minute increments for early drop-off before 7:00a.m. or for late pick-up after 6:00 p.m. as according to the facility clock.

_____ I understand & agree to pay tuition or co-pay for each week of service, including weeks that the center may be closed for holidays (see Parent Handbook for specific closing dates).

_____ I understand that I may be financially responsible for days that exceed the allotted number of absent days or holidays per voucher agreement. DHS requires all families to sign child in/out daily. Failure to do so may be deemed an absent day.

_____ I understand I will default to Private Payer tuition & fees should vouchers become cancelled or void.

In the event that I default on the above agreement and do not make a payment within two weeks, my child’s enrollment may be terminated and I will be responsible for the costs of collection.

Parent/ Guardian Signature _____ **Date** _____

SHAKEN BABY SYNDROME

I have read information on Shaken Baby Syndrome in the Mary’s Little Lambs Parent Handbook.

Parent/ Guardian Signature _____ **Date** _____

**MARY'S LITTLE LAMBS PRESCHOOL
DISCIPLINE POLICY**

Discipline will be appropriate to the developmental level of the child. Positive guidance and redirection will be enforced. Children will be given choices when resolving a situation and will also be asked for their own input on how to make the situation better. This will help them to learn to make positive, responsible choices and to get along with other children. Children will always be praised when they are doing something positive. If it becomes necessary, time-out or time-away will be administered for one minute per age of child (only applies to children 2 years and up). Discipline will never be physical or associated with food or toileting.

I have read and understand the discipline policy of the childcare facility. I give my permission for the use of all methods set out in the handbook.

Parent/ Guardian Signature _____ **Date** _____

HIPAA Release For Allergy and Medical Postings

I authorize Mary's Little Lambs Preschool to post my child's allergy/medical alert/diet restrictions in their assigned classroom, in the kitchen and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Parent/Guardian Signature _____ **Date** _____

CONSENT FOR CHILD DEVELOPMENT SCREENING

Our center offers free developmental screening by our trained staff members using the assessment tool Ages and Stages, an approved provider of Continuing Education. This is an opportunity for parents to be informed of your child's developmental skills in early childhood education. All results will remain confidential and released only upon parental request and Parent/Teacher Conferences.

Parent/Guardian Signature _____ **Date** _____

Mary's Little Lambs Preschool is required by Arkansas State licensing to inform parents that your child(ren) is subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. **(Child interviews do not require parental notice or consent.)** We will make an effort so that a member of management can be present with your child shall this situation occur.

I/We have read and understand the above statement and will comply with the requirements necessary with Mary's Little Lambs Preschool.

Parent/Guardian Signature _____ **Date** _____

CHILD'S PERSONAL INFORMATION

Child's Name _____ **Age** _____

Birthday _____

Does your child have a special toy, blanket, song, etc...?

Child's favorite foods, games, videos: _____

Is your child toilet trained? _____

Physical or emotional problems your child might have: _____

Are there any cultural or child-rearing practices for us to be aware of?

Special problems: Medications _____

Allergies ___ Temper Tantrums ___ Diabetes ___ Frequent colds ___ Biting ___

Sun Sensitivity ___ Seizures ___ Fainting Spells ___ Bed wetting ___ Other ___

Any siblings? If so, what are their names and ages? _____

Other useful information: _____

<THIS SPACE INTENTIONALLY BLANK>



AUTHORIZATION AGREEMENT AUTOMATIC PAYMENTS (ACH BANK DEBITS)

I, _____, hereby authorize **MARY’S LITTLE LAMBS PRESCHOOL**, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION to credit and/or debit the same to such account. *There is a \$15.00 fee for all returned debits/checks.*

(Financial Institution Name)

(Branch)

(Financial Institution Address)

(City/State/Zip)

Please print legibly:

(Routing Number)

(Account Number)

Type of Account: Checking Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

(Signature)

(Date)

(PRINT Account Holder Name)

Print your child’s name here

HOW WOULD YOU PREFER YOUR ACCOUNT TO BE DEBITED?

WEEKLY BI-WEEKLY

****PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM****



AUTHORIZATION AGREEMENT AUTOMATIC PAYMENTS BY CREDIT/DEBIT CARD

I, _____, hereby authorize **MARY’S LITTLE LAMBS PRESCHOOL**, herein after called COMPANY, to initiate charged/debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below. *There is a \$15.00 charge for all chargebacks/retrieval fee.*

Please check one and print legibly:

VISA _____ MasterCard _____ Discover _____ Amex _____

Credit Card Number Expiration Date CSC (3 digit on back) Billing Zip code

****NOTE: There is an added surcharge fee rate of 0.95% up to 3.50% per every swipe depending on your credit card company.**

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

(Signature)

(Date)

(PRINT Card Holder Name)

Print your *child’s* name here

Email receipt to: _____

HOW WOULD YOU PREFER YOUR ACCOUNT TO BE CHARGED?

_____ WEEKLY _____ BI-WEEKLY

| |
|------------------------------|
| <i>OFFICE USE ONLY</i> |
| Date Screener Received _____ |
| Date Office Received _____ |

Regional Therapy Services, Inc.

www.regionalthrapy.net

FREE DEVELOPMENTAL SCREENING

Mary's Little Lambs Preschool

Birth to 6 years

We provide free developmental screenings as a community service for children throughout Northwest Arkansas at their childcare center. This is a great opportunity for parents to be informed of your child's skills necessary for normal development. These skills are vital to your child's educational experiences. We strive to ensure that children meet their full potential. You will receive information regarding your child's screening once it is completed- usually within 3-4 weeks. Feel free to contact us if you have further questions or concerns regarding your child's development. We are glad to serve children and families of Northwest Arkansas.

- Deedra Branscum, Lead Therapist, Call or text (479) 790-7979
- Meghan Delaney, BS, Certified Child Dev. Specialist, Call or text (417) 343-2997

Child's Name _____ Date of Birth _____

Parents Name _____ Phone # _____

Insurance Type: Medicaid/AR Kids yes no Other Insurance Type _____

NOTE: We do not bill for the free screening service. This information is used to determine type of testing and qualifying criteria for the screening as different insurances have different requirements.

Child's main language: English _____ Other (please list) _____

Concerns:

Legal Guardian/Parent Signature

Date