

International Learning Center

SMS Investments, LLC

2035 South Dayton St Denver CO 80247 Telephone: 720.535.8222 Fax: 720.535.8728 Email: interlcenter@gmail.com

FOR OFFICE USE ONLY: (PLEASE LEAVE BLANK, TO BE FILLED BY ADMIN)

ENROLLMENT APPLICATION

STUDENT NAME:

DATE:

***DAYS OF THE WEEK YOUR CHILD WILL ATTEND THE CENTER

MONDAY **TIME IN** -----/OUT-----

TUESDAY **TIME IN** -----/OUT-----

WEDNESDAY **TIME IN** -----/OUT-----

THURSDAY **TIME IN** -----/OUT-----

FRIDAY **TIME IN** -----/OUT-----

ALL PAYMENTS ARE DUE IN ADVANCE

FACILITY TOUR SCHEDULE ON:

PAYMENT RECEIVED ON (MM/DD/YYYY):

AMOUNT: \$ **CASH()** **CHECK # ()** **CREDIT()** **DEBIT()** **OTHER ()**

REGISTRATION FEE: **Y** **N** **AMOUNT:**

RECEIVED BY:

ENROLLMENT DATE:

START DATE:

PARENT CONTACT NAME AND NUMBER

NAME:

ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE:

EMAIL:

CENTER STAFF SIGNATURE

DATE:

International Learning Center

Child Enrollment Form

Enrollment Agreement

International Learning Center

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.

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			Grade			School phone	
School address				Drop off time			Pick-up 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	
								Receive Text Y N	
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	
								Receive Text Y N	
Home address if different from above				City			State		Zip
Personal email			Work email				Work phone		
Employer		Employer address			City		State	Zip	Work hours
Child Authorized and Emergency Contact Release Information (do not include parents/guardians/sponsors)									
Please notify the center if an Emergency Release 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 pick-up.]									
Contact #1		Relationship to child			Home phone			Cell phone	
Home address				City			State		Zip
Personal email			Work email				Work Phone		
Employer		Employer address			City		State	Zip	Work hours
Contact #2		Relationship to child			Home phone			Cell phone	
Home address				City			State		Zip
Personal email			Work email				Work Phone		
Employer		Employer address			City		State	Zip	Work hours
Contact #3		Relationship to child			Home phone			Cell phone	
Home address				City			State		Zip
Personal 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. The emergency Authorized contacts will also be contacted and authorized to remove the child from the facility in case of illness, accident or emergency. 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 Signature _____ Staff initial _____ Date _____

Medical Health 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 If Yes Please Explain _____

2. Does your child have any chronic illnesses? No Yes Explain _____

3. Please list a brief history of your child's serious injuries, major surgery 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? (Please attach care physician instructions and notes if apply) 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 and add the date)

<input type="checkbox"/> Chicken Pox (Varicella) _____	<input type="checkbox"/> Bronchiolitis _____	<input type="checkbox"/> Botulism _____
<input type="checkbox"/> Measles Rubeola _____	<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) and (Attach care physician note if apply)

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	
_____	_____		

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)

<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 _____

To the best of my knowledge the information contained above is accurate.

Parent Signature _____ Staff initial _____ Date _____

Medical Health 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
Physician's practice address	City	State
Preferred hospital/clinic for emergency care address	City	State
Phone		
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State
Dentist's practice address	City	State
Phone Number:		

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 and current well-child visit form including a physical (See List and Forms section please)

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 annually in accordance with state child care regulations.	Parent Signature
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 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 2 hours 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.	Parent Signature
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.	_____

I give my permission to this center to apply sunscreen (A physician Note is required)	Initial
I understand that I must supply my own sunscreen with a valid expiration date, and it will be labeled with my child's name.	_____
The type of sunscreen I will provide for my child is _____	_____
I have special instructions for the application process. <input type="checkbox"/> None <input type="checkbox"/> _____	_____

Parent Signature _____ Staff initial _____ Date _____

Rate Agreement and Contract

Child's name	Birth date
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Hours of Operation

****5% will be deducted if you pay on advance and on a monthly basis* (Please see office admin for details)****

*** *All Tuitions is to be paid in advance****

Regular operating hours are **Monday through Friday from 6:30 AM to 6:30 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 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 Channel 4, 7, 9 and Fox31. A pre-recorded message will be recorded in the center's main phone. **The center follows Aurora Public School , Denver Public Schools, or Cherry Creek School closures due to inclement weather.** 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 days and hours that I wish to contract for child care are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

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

Fee Policy

Please sign and date the Tuition Agreement Form (Attached to this application)

Initial

- Tuition is due and payable on the first business day of the week.
 the 1st and 15th of the month or next business day.
 first business day of the month.
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather)
- Tuition is subject to increase
- I agree to pay the full tuition in advance of services rendered.
- All returned checks or ACH transactions (automatic debits) will be charged a fee up to the maximum amount allowed by law. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status.
- A receipt will be provided.

Parent Conferences

Family & teacher conferences occur annually and as needed. During these conferences, we will discuss your child's strengths, likes and dislikes, and styles of learning. We will work together to set goals for your child's growth and development. You may request additional conferences regarding your child's progress at any time. We encourage you to communicate any concerns.

Initial

Media Release (TV, Video, Internet, Facebook, Twitter, Marketing, etc...)

Initial

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.

Yes, Allow my child's (Media Release) to be used for the center only Parent Signature _____

NO, I don't allow my child (Media Release) to be used for any reason, unless I authorize it with a written and signed form _____

Medications

****A separate form is to be signed from physician and family for all medicine including (Tylenol, Ibuprofen, Sunscreen and OR all [OTC] Over the Counter medications) ****

All medications should be handed to a staff member with specific instructions for administration. Medications should never be left in the child's cubby or with the child to administer on their own. Our staff will ensure that the medication is recorded along with the directions and proceed to dispense the medication as directed.

- **Prescription medications** require a note signed by the family and a written order from the child's physician. The medication must include your child's name, dosage, current date, frequency, and the name and phone number of the physician. All medications must be in the original container (you may request pharmacies to fill your prescription in two labeled bottles). Please specify the dosage and time(s) to be administered for each medication. Medication will be administered in the office.
- **Non-prescription medications** require a note signed by the physician. Non-prescription medication should not be administered for more than a 3-day period unless a written order by the physician is received.
- **Non-prescription topical ointments** (e.g., diaper cream) require notes and or forms signed by both physician and family, specifying frequency and dosage to be administered.
- Sunscreen must be brought in by the parents and the bottle needs to be labeled with the child's first and last name.

Parent Signature _____

Injuries/ accident report

Safety is a major concern in child care and so daily safety inspections are completed inside and outside the center area in order to prevent injuries. First aid will be administered by a trained caregiver in the event that your child sustains a minor injury (e.g., scraped knee). **You will receive an incident report outlining the incident and course of action taken.** If the injury produces any type of swelling or needs medical attention, you will be contacted immediately. Each classroom is equipped with a first aid kit meeting the state regulations. In the event of a serious medical emergency, the child will be taken to the hospital immediately by ambulance, while we will try to contact you or an emergency contact.

Parent Signature _____ Staff initial _____ Date _____

Other Agreements (continued)

Child's name

Birth date

Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.

Initial

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 **Family 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* and the *Family Handbook*.

Primary Parent/Guardian/Sponsor Signature _____

Date _____

Center Staff Signature _____

Date _____

Child Full Name: _____

Date of Birth: / /

Age: _____

I. Permission to Participate

I, hereby give my permission for my child, _____, to use all of the play equipment and participate in all the activities in the center.

Parent/Guardian

Signature _____ Date _____

II. Personal Belongings

Money, toys and other personal belongings should not be brought to the center. I understand that the center is NOT responsible for personal belongings brought by my child/Children.

Parent/Guardian

Signature _____ Date _____

.....

III. Photo/Pictures

During special activities the center may take photos/ pictures of your child and display them in the class rooms, and or hallways. If you don't agree, Circle No and initial ONLY please.

Parent/Guardian

Signature _____ Date _____

NO, I don't gave permission to photo/picture my Child Initial _____

IV. Permission to sleep on a Mat/ Cot

I hereby give permission for my child/children:

To sleep on mat/cot during naptime

Parent/Guardian

Signature _____ Date _____

V. Video/ TV Viewing

I authorize my child to view appropriate child age video/TV for educational purpose only. No marketing or advertising programs will be viewed.

Parent/Guardian

Signature _____ Date _____

VI. Diaper Rash Ointment Permission

I give permission to the employees and staff of International Learning Center to apply diaper rash ointment to my child/children when changing diapers. I understand that rash ointment may not be applied to broken skin. (A signed physician note is required to apply diaper rash)

Parent/Guardian

Signature _____ Date _____

VII. Child Protection

I understand that the staff employee by International Learning Center are required by law, to report any evidence or knowledge of suspected child abuse to the county department of social service and to the law officials.

Parent/Guardian

Signature _____ Date _____

VIII. Field Trip Authorization

I hereby grant permission for my child, _____, to leave the center premises under the supervision of staff member for either walking excursions and field trip in authorized and insured vehicles.

Parent/Guardian

Signature _____ Date _____

IX. Medication

I hereby grant permission for my child, _____, to be given prescription and non prescription medications (With doctor's written authorization ONLY) at the center if needed. I agree to follow all necessary steps as stated by the Colorado Department of Child Care.

Parent/Guardian

Signature _____ Date _____

X. Sunscreen Permission

Your childcare provider will assist with applying sunscreen to bare surfaces 15-30 minutes before outdoor activities. It's the parent's responsibility to provide sunscreen with a minimum SPR of 15. I give permission for my child to have sunscreen applied by the staff at International Learning Center as described above (A note from Child's physician is required)

Parent/Guardian

Signature _____ Date _____

I. Authorization for Emergency Treatment

I /We do hereby authorize the adult leader or agents on behalf of international learning center to act as agents for the undersigned; to consent to any medical or surgical diagnosis or treatment or hospital care Deeside advisable by or administered by a licensed physician, in the even such help of an emergency becomes necessary

Physician's Name: _____ **Phone:** _____

Address: _____ **City** _____ **State:** _____

Telephone: _____

Parent/Guardian

Signature _____ **Date** _____

II. Policy Agreement

I hereby agree that I have received, read and agree to all the policies and procedures at International Learning Center as stated in the enrollment form and the parent hand book. I, also agree to give a two week notice of withdraw to avoid additional tuition charges.

Parent/Guardian

Signature _____ **Date** _____

General Health Appraisal (6 Weeks -16 Years) for enrollment into Child care

*****Must be completed by a health care professional*****

Child Name: _____

Birth Date: / /

Health History and medical information pertinent to child care emergencies:

_____ None _____ If yes, please describe below:

Special Diet:

Allergies and types of reactions:

Current Medications including OTC (Over The Counter Medications):

Describe any recurrent health problems (Such as asthma, seizures, ear infections, diabetes, etc..) illness, hospitalization or concerns with development:

Please include any instructions (if any) to a child care provider(s):

Dates most recent examination of child (Note: within the last 12 months)

Weight _____

Heights _____

Vision _____

Hearing _____

******Please attach immunization record. No child will be admitted and or enroll without updated immunization record****
No Exceptions by Colorado Child care Rules and Regulations.**

Health care provider Name: _____ Date / /

Health care provider signature:

Address: _____ State _____

City _____ Zip code _____

Telephone _____

I, _____ give permission for my child's health provider and child care provider to discuss my child's health concerns.

Parent/ Guardian Name: _____

Signature: _____

Date: _____

TUITION AGREEMENT**International Learning Center****Hours of Operations: 06:30am to 06:30 pm Monday-Friday****Ages accepted 6 weeks to 16 years**

2035 S. Dayton St Denver Co 80247 Phone: 720.535.8222 Fax: 720.535.8728

Child's Name: _____ Date of Birth: - -

Age:

Parent's Name: _____

Days of Attendance Monday () Tuesday () Wednesday () Thursday () Friday ()**Tuition:** Daily () Weekly () Bi-Weekly () Monthly ()**Start Date** - - **Classroom**

1. **All Payments are due in Advance**
2. **Registration Fees:** A non-refundable registration fee are due by enrollment of \$70.00 for a single child or \$100.00 for a family (More than one child)
3. **Tuition:** Tuition is due on Monday or your child's first attending day for that week. Tuitions that have not been paid by Wednesday prior to closing of business a late fee of \$10.00 per day will be assessed. If tuition is NOT paid by Friday, an interruption of service will be affective Monday of the following week and the account will become delinquent which and will be subject to collection services. All court and reasonable legal fees for collection will be added as well.
4. **Late Pick-up Fee:** A late fee of \$1.00 per minute per child will be assessed after 06:30 pm. That fee is to be paid within 24 hours.
5. A late fee of \$35.00 will be charged for any returned payment
6. **Hours of Operations:** 06:30 am to 06:30 pm Monday – Friday
7. **Holidays:** Holidays are counted as part of the tuition even though the center is closed. The center will be closed on: -New Year's Day – Memorial Day – Independence Day– Labor Day – thanks giving Day – Christmas Eve – Christmas Day - New Year's Eve. Full Tuition is due for the weeks in which these holidays observed. When holiday falls on a Saturday, the Center will be closed Friday. When the holiday falls on a Sunday, the Center will be closed Monday.
8. **Vacation:** Each child is permitted one week of vacation (in any 12 months consecutive calendar per enrollment/ year) without paying the tuition.
9. **Re-entry Fee:** if your child is going to be out more than a week, re-entry fee of \$50.00 per child or \$75.00 per family will be charged. Re-entry is subject to availability.
10. **Field Trips:** Additional fees might apply for field trips and special events.
11. **Attendance and absence:** All children are expected to attend on their scheduled days per this agreement. There will be no credit for absent days as they count as regularly attended days.
12. **Withdraw Procedure:** The center must be notified in writing at least 2 weeks prior to the withdraw date. Without written notice the parent/guardian will be responsible for the 2 weeks of tuition. Parents/guardians will be held liable and turned over to a collection agency for any unpaid balance.
13. **Unacceptable behavior Policy:** For the safety of our children and staff, International Learning Center CANNOT allows any child to use physical violence or inappropriate languages. Child will be subject to disciplinary action ranging from time out to suspension depending on the severity of the offense.
14. **CCAP Parent: Must pay co-Pay (Parent Fee) by the 3rd of every month, if NOT paid by the 10th a late fee will be assessed.**

Parent/Guardian Name:

Signature:

Date: - -

APPLICATION CHECK LIST

Please make sure to:

- ✓ Sign and initial All pages
- ✓ Enrollment and tuition fee
- ✓ Immunization Record
- ✓ Physical and General Health appraisal form
- ✓ Authorization Forms signed
- ✓ Parent Hand book acknowledgment
- ✓ Tuition Fee agreement