**The Children's Village Early Learning Center**
**567 South County Trail**
**Exeter, RI 02822**
**Phone: 401-295-5240 Fax: 401-295-5246**
**Email: susan@thechildrensvillage.net**

**Child's Name _____**

**Child's Birth Date _____**

**Parent/Guardian's Name _____**

**Phone _____Email _____**

**Address _____City/State _____Zip_____**

**Employer _____Phone _____Email _____**

**Parent/Guardian's Name _____**

**Phone _____Email _____**

**Address _____City/State _____Zip_____**

**Employer_____ Phone _____ Email _____**

**Classroom (circle one): Infant Toddler Preschool Pre-K**

**Days (circle the days your child will attend):**

**Monday Tuesday Wednesday Thursday Friday**

**Drop-off Time:_____ Pickup Time:_____**

**Start Date _____**

**Child Care Assistance Number (if applicable):_____**

**A $35.00 registration fee and deposit of two-weeks tuition is due to secure placement.**

# PARENT AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I _____ (Parent or Guardian) hereby authorize The Children's Village to arrange medical examination and/or treatment of my child _____ (Child's name), should an emergency arise at the center. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided below, before any medical action is taken. I would prefer to have my child, if the need arises, taken to _____ hospital.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Name | Home/Cell Phone | Work Phone |
| _____ | _____ | _____ |
| Parent/Guardian Name | Home/Cell Phone | Work Phone |

Emergency/authorized persons to pick up if you cannot be contacted in an emergency or sick situation.

Name _____ Phone_____Relation _____

Name _____ Phone_____Relation _____

Name _____ Phone_____Relation _____

_____

Medical Insurance Policy Number

_____

Policy Holder's Name

Allergies to food or medication _____

## Consent for Release of Information

**Child's Name:**_____

**Child's Date of Birth:**_____

I authorize the following agencies to release information or records about my child to **The Children's Village** (please list all services involved with your child):

- **Pediatrician:**

  Name:_____ Phone Number:_____

- **Early Intervention:**

  Name:_____ Phone Number:_____

- **Department of Children, Youth and Families:**

  Name:_____ Phone Number:_____

- **School Department:**

  Name:_____ Phone Number:_____

- **Other:**

  Name:_____ Phone Number:_____

Medical information is protected under RI and Federal Laws and, except as provided by law, cannot be disclosed without written consent. Information released by this authorization will not be given, sold, transferred or relayed to any person or agency not specified above. This authorization is valid for 12 months from the date below, but may be withdrawn at any time by submitting a written revocation.

**Signature:** _____ **Date:**_____

**Relationship to Child:**_____

# Tuition Deposit, Payment & Vacation Policy

## Tuition Deposit

A two-week deposit is required to secure placement. One week will go towards the first week of enrollment and one week will be held until your last week of enrollment. Disenrollment of your child requires a two week written notice.

## Payment Policy

Tuition payments for the following week will be due on the Thursday prior. You can pay weekly, bi-monthly or monthly. Parents who are paying by cash or check are required to leave payment in the morning during drop off time. Our tuition box is located in the foyer. For your convenience, we also accept ACH payments through our communication app, Brightwheel, with no fees. Credit cards are also accepted on Brightwheel. A $5.00 processing fee will be applied to each transaction when using a credit card.

Please indicate which options you choose for tuition payments:

| | | | |
|---|---|---|---|
| (circle one) | Weekly | Bi-Weekly | Monthly |
| (circle one) | Cash or Check | Bank Transfer (ACH) | Credit Card |

Tuition is paid regardless of sickness, holidays, closing due to inclement weather and vacation time. A $25.00 late fee will be applied for late payments. A $35.00 fee will be applied for any returned checks.

## Vacation

Children enrolled full time are eligible for 1-week vacation credit per year, based on their start date. You must be enrolled for 6 months before eligibility.

**I have read and fully accept the terms listed in the payment policies for The Children's Village.**

**Parent/Guardian's Signature _____**

**Date _____**

# WAIVER OF LIABILITY

In consideration of the acceptance of this application, we/I

_____and _____
Parent/Guardian Parent/Guardian

waive our rights to commence any legal action or bring any claim against The Children's Village, Inc. in connection with any injuries sustained by my child. Upon acceptance of the registration fee and deposit, we/I understand that this agreement will be a binding contract enforceable by both parties.

Parent/Guardian's Signature _____

Parent/Guardian's Signature _____

# PHOTO RELEASE FORM

Please circle your choice and sign.

CHILD'S NAME_____

I give The Children's Village permission to photograph my child. I understand that these photos may be used on The Children's Village web site and/or other advertising opportunities.

_____

PARENT'S OR GUARDIAN'S SIGNATURE DATE

I DO NOT give The Children's Village permission to photograph my child. I DO NOT want my child in any advertising or on the web site.

_____

PARENT'S OR GUARDIAN'S SIGNATURE DATE

| School Name & Address: | | Health Care Provider Name and Address: |
|---|---|---|
| | **STATE OF RHODE ISLAND**<br>**SCHOOL PHYSICAL FORM** | Phone: |

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

| Student Name: Last | First | Middle | | Date of Birth | Sex |
|---|---|---|---|---|---|
| Address: Street | Apt # | City | State | Zip Code | Home Phone |

**PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).**

| IMMUNIZATIONS | Please enter dates in MM/DD/YYYY format | | | | |
|---|---|---|---|---|---|
| Hepatitis B | | | | | |
| Diphtheria-Tetanus-Pertussis DTP/DTaP | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT | Check ☐ if DT |
| Pneumococcal Conjugate PCV | | | | | |
| Polio | | | | | |
| Haemophilus Influenzae Type B Hib | | | | | |
| Measles-Mumps-Rubella MMR | | | | | |
| Varicella | | | ☐ Student has history of varicella disease | | |
| Tetanus-Diphtheria-Pertussis TdaP/Td | Check ☐ if Td | Check ☐ if Td | Check ☐ if Td | | |
| Rotavirus | | | | | |
| Hepatitis A | | | | | |
| Meningococcal | | | | | |
| HPV | | | | | |

**Immunization Exemption:** ☐ Medical ☐ Religious

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV

**PHYSICAL EXAMINATION**

**Date of PE** ____/____/____ **Height** _____ **Weight**_____ **BP**_____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

**ASTHMA: No ☐ Yes ☐** **DIABETES: No ☐ Yes ☐** **OTHER:** _____

Significant Systems Findings: _____

**ALLERGIES: No ☐ Yes ☐ (Please explain)** _____ **EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐**

Treatment Plan: _____

**MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list)** _____

Other medication(s) that may affect behavior or health at school: _____

**RESTRICTIONS:** Can participate in physical education: Fully☐ With limitation ☐ _____

Can participate in sports: Fully☐ With limitation ☐ _____

| LEAD SCREENING (Required for children < 6 years of age only)<br>Student is in compliance with lead screening requirements:<br>Yes ☐ No ☐ | SCOLIOSIS SCREENING<br>Yes ☐ No ☐ | VISION SCREENING (Children entering Kindergarten)<br>☐ Passed screening<br>☐ Screened and referred for comprehensive exam<br>☐ Referred for comprehensive exam, but not screened |
|---|---|---|
| TUBERCULOSIS (If required by school district)<br>Date of TB test: | | Screening Date: Comprehensive Exam Date: |

**HEALTH CARE PROVIDER SIGNATURE:** _____ **DATE:** _____

**PRINT NAME:** _____

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# PRE - K SOCIAL RESUME

Child's Name: _____

**Food**

Describe your child's appetite: _____
_____

Does your child have any food sensitivities? ☐ Yes ☐ No
If yes, please identify: _____
_____

Is your child under medical care for this allergy? ☐ Yes ☐ No
If yes, please submit an individualized care plan.

Do you give consent for The Children's Village to post information about your child's food allergy? ☐ Yes ☐ No

**Self-Care**

Does your child need any help with dressing? □ Yes □ No

Does your child need assistance in the bathroom? ☐ Yes ☐ No

**Sleep**

Describe your child's sleep routine (lengths of naps, bedtime and waking time):
_____
_____

Describe any sleep problems or disorders that your child may have
_____
_____

**Social/Emotional Development**

Does your child separate easily from you? ☐ Yes ☐ No

What toys/activities does your child enjoy? _____
_____

What toys/activities does your child dislike? _____
_____

How do you handle discipline in your home? _____
_____

What are you able to contribute to your child's education? (talents, interests, classroom volunteer…etc)
_____
_____
_____

Please provide any other information relating to your child that would be helpful in understanding, educating and caring for your child:
_____
_____
_____
_____
_____
_____
_____

_____ _____
Parent/Guardian Signature Date