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	e			
Phone	Ema	il		
Address		City/State		_Zip
Employer		Phone	Email	
Parent/Guardian's Name	e			
Phone	Ema	il		
Address		City/S	State	Zip
Employer		Phone	Email	
Classroom (circle one):	Infant	Toddler	Preschool	Pre-K
Days (circle the days you	ır child will a	ttend):		
Monday	Tuesday	Wednesday	Thursday	Friday
Drop-off Time:		Pickup Time	.	
Start Date				
Child Care Assistance N	umber (if app	olicable):		

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	e, I			(Parent or
Guardian) hereby authorize T	he Children's Vill	age to arrange med	lical exa	mination and/or
treatment of my child		(Chi	ild's nam	e), should an
emergency arise at the center	. It is understood	that a conscientiou	s effort v	vill be made by the
school to contact me at the en	•			•
action is taken. I would prefe			, taken t	0
	hos	pital.		
D (C 1' N				
Parent/Guardian Name		Home/Cell Phone		Work Phone
Parent/Guardian Name		Home/Cell Phone		Work Phone
Tarent/Guardian Ivanic		Tionic/Cen i none		WOLK I HOLE
Emergency/authorized person	ns to pick up if you	u cannot be contact	ted in an	emergency or sick
situation.	is to prom up in jos			omergency or stem
2.4.W.W.2.0 1.1				
Name	Phone	Re	lation	
Name	Phono	Po	lation	
Name	FIIONE_			
Name	Phone_	Re	elation	
Medical Insurance		Policy Number	r	
D 1' II 11 1 3 3				
Policy Holder's Name				
Allowsia to food a constitution				
Allergies to food or medication	on			

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.

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

Please indicate which options you choose for tuition payments:

Weekly

(circle one)

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 phunderstand that these photos may be used on site and/or other advertising opportunities.	
PARENT'S OR GUARDIAN'S SIGNATURE	DATE
I DO NOT give The Children's Village permi child. I DO NOT want my child in any adver	1 0 1
PARENT'S OR GUARDIAN'S SIGNATURE	DATE

School Name & Address:

PRINT NAME:



Health Care Provider Name and Address:

STATE OF RHODE ISLAND 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 Bhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4).

	Fi	rst		Middle		Date of Birth	Sex
ddress: Street		Apt#	City		State	Zip Code	Home Phone
LEASE COMPLETE ALL INFORM	ATION BELOW (May atta Please enter dates in M						
Hepatitis B	Prease enter dates in in						
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check if DT	Check i	fDT	Check ☐ if DT	CI	eck 🗖 if DT	Check ☐ if D
Pneumococcal Conjugate PCV Polio							
łaemophilus Influenzae Type B			-+				
Hib Measles-Mumps-Rubella MMR							
Varicella			-	Student has history	of varicella dis	ease	
Tetanus-Diphtheria-Pertussis TdaP/Td	Check ☐ if Td	Check 🗖 it		Check ☐ if Td			
Rotavirus							
Hepatitis A							
Meningococcal							
HPV							
□ Hep B □ DTaP □ PC HYSICAL EXAMINATION Date of PE/ Please note any health p		Height		Weight		rus Hep A	■ Mening ■ H
ASTHMA: No 🗖 Yes 🗖	DIABETES	S: No 🗖 Yes 🗖	OTHE	R:			
Significant Systems Find	fings:						
Significant Systems Find ALLERGIES: No □							UIRED: No 🗖 Yes I
Significant Systems Find ALLERGIES: No Treatment Plan:	ings: Yes (Please explain)			EF	INEPHRINE AL	ITO-INJECTOR REQ	
Significant Systems Find ALLERGIES: No Treatment Plan: MEDICATION (REQUIR	fings:	Yes 🗆			INEPHRINE AL	ITO-INJECTOR REQ	
Significant Systems Find ALLERGIES: No Treatment Plan: MEDICATION (REQUIR Other medication(s) that	Yes (Please explain)	Yes alth at school:	(Please list)	EF	INEPHRINE A	ITO-INJECTOR REQ	
Significant Systems Find ALLERGIES: No Treatment Plan: MEDICATION (REQUIR Other medication(s) that RESTRICTIONS: Can p	Yes (Please explain) ED AT SCHOOL): No may affect behavior or her	Yes alth at school:	(Please list)	EF	INEPHRINE AL	ITO-INJECTOR REQ	
Significant Systems Find ALLERGIES: No Treatment Plan: MEDICATION (REQUIR Other medication(s) that RESTRICTIONS: Can p	Yes (Please explain) ED AT SCHOOL): No may affect behavior or her participate in physical educ participate in sports: thildren < 6 years of age or reening requirements:	Yes aith at school: ation: Fully Fully	(Please list)	With limitation With limitation With limitation With Similar Wision Passe	SCREENING (C) dd screening ned and referre	ITO-INJECTOR REQ	dergarten)

PRESCHOOL SOCIAL RESUME

Cliid's Name:
Food Describe your child's appetite:
Does your child have any food sensitivities? \square Yes \square No
If yes, please identify:
Is your child under medical care for this allergy? $\ \square$ Yes $\ \square$ 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? \square Yes \square No
Self-Care
Is your child potty trained? \Box Yes \Box No Comment:
Does child need assistance in the bathroom? \Box Yes \Box No
Please describe:
Does your child need any help with dressing? $\ \square$ Yes $\ \square$ No
Sleep
Describe your child's sleep routine (include 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? \square Yes \square No
Is your child afraid of anything? \square Yes \square No
Does your child have a favorite toy, blanket or soother? \square Yes \square No
Does your child spend time with other children? \Box Yes \Box No

How do you handle discipline in your hom	e?
What are you able to contribute to your ch classroom volunteeretc)	hild's education? (talents, interests,
•	9 ,
Please provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide any other information related helpful in understanding, educating and control of the provide and the pr	9 ,