

**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:	 STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM	Health Care Provider Name and Address:
		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 <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			<input type="checkbox"/> Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis TdaP/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> 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) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed screening <input type="checkbox"/> Screened and referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened Screening Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

TODDLER SOCIAL RESUME

Child's Name: _____

Family

Does your child have pets? If so, what are they? _____

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

Is your child in diapers? Yes No Comment: _____

Has training begun? Yes No Comment: _____

Is your child trained? Yes No Comment: _____

Does child need help? Yes No Comment: _____

Does your child need any help with dressing? Yes No

If yes, please list: _____

Sleep

Describe your child's sleep routine (include naps & lengths of naps):

Social/Emotional Development

Does your child separate easily from you? Yes No

Please comment: _____

How do you handle discipline in your home? _____

What characteristics in your child's development would you like:
Encouraged? _____

Discouraged? _____

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 and caring for your child: _____

Date: ___/___/___
 D M Y

Parent/Guardian signature