



## Enrollment Packet

Thanks for your interest in Growing Kids Learning Centers. The Enrollment Process is as easy as...

- 1) Complete the Enrollment forms  
Bring them with you when you tour or before your child's first day.
  
- 2) Call or Meet with the Center Director to coordinate an enrollment opening and schedule a start date.  
Availability is limited and changes frequently. Children are enrolled on an as-available basis.

This Packet Includes the following forms to complete:

- o Tuition Agreement
- o Enrollment Form
- o Authorized Pick Up List & Emergency Contacts
- o Parent Questionnaire
- o Verification of Age and Consent to Report
- o Health Record (must be completed within 30 days of enrollment)
- o USDA/CACFP Food Program (for all families)

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Preferred Start Date: \_\_\_\_\_

**Thank you for choosing Growing Kids Learning Center.**



# Tuition Agreement

<b>Programs Available</b> (Please circle one. Ask the Director if more options are needed.)			
Infant Care (6 weeks – Walking)	5 Full Days (7:00 am - 6:00 pm)		
Toddler Care (Walking - 24 Months)	5 Full Days		
Young Preschool (24mo. - 3 years)	5 Full Days	5 Half Days	3 Full Days
Preschool (3 yrs & Potty Trained - 5 years)	5 Full Days	5 Half Days	3 Full Days
Kindergarten (5 yrs. by September 1)	5 Full Days	5 Half Days	
After School Care (Elem. Grades)	5 Days	Additional charges apply for extra ½ and full days.	
Evening Care (2 yrs and older)	Care available until 11:30 p.m. weekly or as needed. <b>Prior sign-up required.</b>		

For the Program Selected,  
Your Weekly Tuition Rate Is:

\$\_\_\_\_\_ If Paid In FULL on  
Monday with **PrePay**  
**Discount**

\$\_\_\_\_\_ Regular Tuition Rate  
(no PrePay Discount)

This amount can change if  
your child's program changes.

### Payments and Due Dates

All Payments are due in advance weekly on Mon. morning.  
Advanced payments are accepted.  
All payments are non-refundable.  
The annual registration fee of \$50 is charged upon enrollment and every August thereafter.  
A Service fee of \$25 is charged for all returned checks.  
Non-Payment of Tuition can terminate enrollment.  
Forms of payment accepted: Debit Cards, Checks, Visa / MasterCard, AutoPay from Checking.

**Parent(s) signing below are responsible for paying any balance due, including any balances remaining after payments from childcare voucher, 3<sup>rd</sup> party reimbursement, or other outside source.**

### Late Pick Up Fees

A fee of \$5 is charged for every 15 minutes a child is picked up after the scheduled pick-up time. Payment is due immediately. See the Parent Handbook for more info.

### Holiday Schedule

The center will be closed on the following holidays (or closest weekday). The regular tuition is still due these weeks. Evening Care schedule may be adjusted as well.

- New Year's Day
- Memorial Day
- July 4<sup>th</sup>
- Labor Day
- Thanksgiving
- Christmas Day

### Schedule or Program Changes

If your child's schedule or program changes, your tuition will change accordingly. To request a schedule change, please notify the director in writing.

To qualify for the PrePayment Discount, your balance must be paid in full by Monday of each week.

Your tuition is due in full each week regardless of illness or other absence. The center does provide 2 weeks "Vacation" per calendar year where tuition is waived when your child does not attend. Vacation requests should be in writing -- Please see the Parent Handbook for details. Overdue accounts will be charged a service fee. The parent understands that he/she assumes all responsibility for interest charges, collection agency, legal or court fees associated with the collection of this account, if that becomes necessary. Parents electing to withdraw their child must provide two weeks written notice to the center. Any issue under this agreement or relating to the service provided shall be subject to mediation and, if not resolved by mediation, arbitration under the rules of the American Arbitration Association.

Child: \_\_\_\_\_

Parents' Signatures: \_\_\_\_\_

Date: \_\_\_\_\_

Director: \_\_\_\_\_



### Student Information

Name: \_\_\_\_\_  
 Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Child Lives With: \_\_\_ Mother \_\_\_ Father  
 \_\_\_ Other: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_\_\_

Start of Care: \_\_\_/\_\_\_/\_\_\_\_\_

Gender: \_\_\_ Boy \_\_\_ Girl

Parents are: \_\_\_ Married \_\_\_ Single

\_\_\_ Other \_\_\_\_\_

In the chart below, please indicate the normal **days and hours** your child is in care, and the **meals received** while in care.

	MON	TUE	WED	THUR	FRI
Please enter the normal hours your child is in care (e.g. 7:30 – 5:30pm)					
Please check (✓) the meals your child normally receives while in care	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack

This information is required by CACFP federal regulations at §226.15(e)(2) and (3) for each enrolled child and must be updated **annually**.

- Check if your child's schedule may vary
- Check if your school aged child might attend before/after school care and school holidays during the school year.

### Parent (Guardian) Information

	First Parent	Second Parent
Relationship	___ Mother ___ Father	___ Mother ___ Father
Name:	_____	_____
Home Address:	_____	_____
City/State/Zip Code:	_____	_____
Home Phone:	_____	_____
Employer Name:	_____	_____
Employer Address:	_____	_____
City/State/Zip Code:	_____	_____
Employer Phone:	_____	_____
Work Hours:	_____	_____
Soc.Sec.# / D.L.:	_____	_____
Email Address:	_____	_____



**Authorization and Consent**

I/We state that we are the legal parent/guardian of the minor child listed below.

Please Initial

\_\_\_\_\_ **Authorization for Medical Treatment of a Minor** – I authorize, for emergency purposes only, Growing Kids Learning Center to consent to any necessary examination, medical diagnosis, surgery or treatment, and / or hospital care to be rendered to the minor child listed below, under the general or special supervision and on the advice of any physician licensed to practice in the state of Indiana.

\_\_\_\_\_ **Liability Release for Services Provided Outside of Growing Kids Learning Center** – I release and hold harmless Growing Kids Learning Center, its owners, and its employees from any liability or accident that may occur should I retain the services of any Growing Kids employee for services **outside** the learning center. I also agree not to solicit Growing Kids employees away from the learning center for alternate employment opportunities.

\_\_\_\_\_ **Photo Release** – Growing Kids, its affiliates and agents, may use photographs, reproductions, images, and sound recordings of my child for advertising, publicity, or other lawful use.

\_\_\_\_\_ **Authorized Pick Up** - Children will be released only to a parent or a person named by the parent. Parents or persons named by the parent must make sure that a staff member is aware of the child’s arrival and departure. Parents shall sign the child in and out by name and time of arrival and departure. Parents cannot share access codes, computer passwords, and other security measures with unauthorized people.

\_\_\_\_\_ **Receipt of Growing Kids Parent Handbook** – I have read and understand the Growing Kids Parent Handbook that was given to me upon enrollment.

\_\_\_\_\_ **Agreement to Pay Tuition** – I have read and signed a Tuition Agreement form that specifies the tuition amount and the frequency of payments to Growing Kids for services rendered.

Name of Child: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank You for Choosing Growing Kids Learning Center**

We are dedicated to providing the highest quality child care. Please feel free to speak with your child’s teacher or the center director regarding any question or concern you may have. We welcome your comments and involvement in the center.

Office Use Only –	Center:
Enrollment Offer Date:	Expected Start Date:
Enrollment Offered by:	Offer Expiration Date:
Classroom / Schedule:	



# Authorized Pick Up List & Emergency Contact List

This form designates what adults are able to pick-up your child from the Growing Kids Learning Center and what adults to contact in the event of an emergency. Please list the adults in the order you would like us to contact them in the event of an emergency or, more likely, a student illness.

Student Name: \_\_\_\_\_

Computer Password: \_\_\_\_\_

Home Address: \_\_\_\_\_

Contact Order	Name	Relationship	Phone Number		
1	Mother or Father		Home: _____	Work: _____	Cell: _____
2	Mother or Father		Home: _____	Work: _____	Cell: _____
3			Home: _____	Work: _____	Cell: _____
4			Home: _____	Work: _____	Cell: _____
5			Home: _____	Work: _____	Cell: _____
6			Home: _____	Work: _____	Cell: _____

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Allergies or Other Restrictions: \_\_\_\_\_

Pick Up Restrictions (legal documentation generally required): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A copy of this form to accompany the child on all field trips.**



**Child Information**

Child's Full Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_  
Name Child is Called \_\_\_\_\_ (circle gender) Male Female

**Please Fill Out the Following Information**

List all persons living in the household

Name	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe child's previous child care experience  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

Type of Birth Normal Premature Complications \_\_\_\_\_

Languages spoken in the home \_\_\_\_\_ Primary Language \_\_\_\_\_

Any difficulties in speaking? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**Circle if child can:**

Crawl Walk (more than 5 steps on own) Put on shoe Button  
Tie shoe Buckle Zip zipper Dress self Feed self

Explain any difficulties in physical development \_\_\_\_\_

**Toilet Training (circle)**

Child is in a Diaper Pull-up Training Pant Underwear  
Child is successful on the toilet Always Urine BM  
Child stays dry All Day Through Nap Through Night  
Child will go to toilet By Self When Asked

**Sleep Habits**

When is child's bedtime? \_\_\_\_\_ When does he awaken? \_\_\_\_\_ Does he/she share a room? \_\_\_\_\_  
With whom? \_\_\_\_\_ Own bed? \_\_\_\_\_ Shared with whom? \_\_\_\_\_  
What is child's general mood upon awakening? \_\_\_\_\_  
Nap Schedule \_\_\_\_\_



Eating Habits

Favorite foods \_\_\_\_\_

Foods disliked \_\_\_\_\_

List any foods child can not eat (Must have a Doctor's note) \_\_\_\_\_

Is child on (circle) Breast Milk Formula 2% milk Other \_\_\_\_\_

Does child drink from a bottle? \_\_\_\_\_ Use a sippie cup? \_\_\_\_\_ Open cup? \_\_\_\_\_

Eat table food? \_\_\_\_\_ Use a pacifier? \_\_\_\_\_ Suck Thumb? \_\_\_\_\_

\* Parents of infants must complete the enclosed Feeding Plan and have it signed by child's doctor.

Social and Emotional Behavior/Experience

Does child have temper tantrums? \_\_\_\_\_ Explain \_\_\_\_\_

Does child pick up toys after playing? \_\_\_\_\_

With what age group does child usually play? \_\_\_\_\_ Favorite Toy? \_\_\_\_\_

How does child relate to new people? \_\_\_\_\_

What upsets your child? \_\_\_\_\_

What makes child happy? \_\_\_\_\_

How does child demonstrate anger? \_\_\_\_\_

How do you discipline at home? \_\_\_\_\_

How best would you describe your child's disposition? \_\_\_\_\_

Child is frightened by (circle)

Animals Loud noises Sirens Darkness Water Other \_\_\_\_\_

Concerns or Comments?

Four horizontal lines for writing concerns or comments.

\_\_\_\_\_ / / \_\_\_\_\_ / /

Parent Signature

Date

Parent Signature

Date





# Child Care Center Health Record

Child's Name (last, first)		Date of Birth	Admission Date
Address			
Child lives with (relationship)	Name		Telephone Number

Medical History		
Communicable Disease	Month / Year	Condition / Explain if Present
Measles		Allergies:
Rubella (German Measles)		
Chicken Pox		Handicapping Conditions:
Mumps		
Scarlet Fever		Other:
Whooping Cough		
Hepatitis B		
Other: _____		

Physical Examination	
Date of Exam:	Age of child:
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
<p>Does this child have any health condition that would be hazardous to the child or to other children in a group setting as a result of participation in normal activities (including sports)? If yes, what modifications of normal activities would be necessary to protect the child and the child's classmates?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	
<p>Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> NO</p>	

(Over)



**History of Immunizations and Tests** (*indicate month/day/year*)

	1	2	3	4	5
DTP/DT/Td					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV					

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
Pneumococcal (PCV)				

	1	2	3
HBV			

Note: To be considered adequately immunized, a child of age 24 months should have received four DTP inoculations, three polio inoculations, one inoculation against measles, mumps, and rubella, and at least 3 Hib vaccinations.

Name of physician completing form (please print)	Telephone Number
Signature of physician	

<b>Additional Notes and Instructions</b>
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# Help Us Provide Better Meals and Snacks!

We need EVERY FAMILY to complete the attached form  
and return it to the office NOW!\*

It only takes a few minutes.

To provide higher quality meals and snacks for the children at the center, this center participates in the US Department of Agriculture's CACFP food program.

For every family enrolled, the center receives some reimbursement from the food program. The center receives *higher* reimbursement when more families properly complete this form.

The funds the center receives from the food program enable us to provide higher quality meals and snacks to the kids at no additional cost to the parents. It is basically an extra source of funds (besides parent tuition).

If you have any questions, please ask. We would be happy to help.

Thanks

\*Why NOW? Because if you take it home, it probably won't come back for awhile...  
We understand. Life gets pretty busy.

(Effective July 1, 2010)

Growing Kids Learning Center  
2601 North Bendix Drive  
South Bend, IN 46628

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Dear Parent or Guardian:

Please help us comply with the requirements of the United States Department of Agriculture's Child and Adult Care Food Program. Complete, sign, and immediately return the attached Application for Free and Reduced-Price Meals. Households with income equal to or below the reduced-price guidelines listed on the following page would be eligible for free or reduced-price meals at no separate charge. This information is necessary so we can receive CACFP reimbursement for the meals served to children in our program. This application will be placed in our files and treated as confidential information.

In order to be considered eligible for free or reduced-price meals, your application must contain the names of all household members and their current incomes before taxes identified by source, the names of children, the social security number of the adult household member signing the application, or an indication that the adult does not have a social security number, and a signature of an adult household member. USDA defines a household as, "A group of related or unrelated individuals who are not residents of an institution or boarding house, but who are living as one economic unit."

If any member of your household is currently receiving Food Stamp or TANF benefits, categorical approval for free meals is automatically given to all children in the household. All that is needed on this application is the appropriate case numbers for either program, the names of the children, and the signature of an adult household member. **Appropriate case numbers are ten digits long and begin with 10.**

In the event that the parent(s) or guardian of the child enrolled becomes unemployed, another application may be completed to determine whether the loss of income makes the household eligible for free or reduced price meals.

Foster children are eligible for free or reduced-price meals regardless of the income of the household in which they reside. If foster children are living with you and you wish to apply for meal benefits, please contact us.

Once properly approved for Free or Reduced-Price meal benefits, a household will remain eligible for those benefits for a period not to exceed 12 months.

Part 7: Children's free and reduced-price meal eligibility information may be shared with other programs. If your children's meals are reimbursed at the free or reduced-price rate, these children may also be able to get free or low-cost health insurance through Medicaid or the State Children's Health Insurance Program (Hoosier Healthwise). Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and Hoosier Healthwise that your children's meals are eligible for the higher reimbursement rate(s), unless you tell us not to.** It will not affect you children's eligibility for free and reduced-price meals. Medicaid and Hoosier Healthwise only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children. (Filling out the Application for Free and Reduced-Price Meals does not automatically enroll your children in health insurance.) Please sign **PART 7** if you do not want information from your Application for Free and Reduced-Price Meals shared with Hoosier Healthwise.

**The USDA and the State of Indiana are equal opportunity providers and employers**

## APPLICATION FOR FREE AND REDUCED-PRICE MEALS

Complete, sign, and return the form to \_\_\_\_\_.

Please read the instructions. If you need help completing this form, call: \_\_\_\_\_.

Name of Child Care Facility: \_\_\_\_\_

OR

Name of Family Day Care Home Provider: \_\_\_\_\_

AND

Name of Family Day Care Home Sponsor: \_\_\_\_\_

**Part 1:** List the names of all enrolled children for which you are submitting this application.

Child's Last Name	Child's First Name	Child's Middle Initial	Child's Date of Birth

**Part 2:** Is this a FOSTER CHILD? If this is a foster child, check here [  ] and write the child's monthly personal use income here: \_\_\_\_\_. Complete a separate form for each foster child. Go to Part #5.

**Part 3:** Are you getting **FOOD STAMPS** or **TANF** benefits for your child or, for **Tier II day care homes**, are you enrolled in any other eligible subsidized benefit program (see instructions)? List the CASE NUMBER. DO NOT complete part #4. Go to part #5.

Food Stamp Case Number: \_\_\_\_\_ TANF Case Number: \_\_\_\_\_

For parents of children in Tier II Day Care Homes only, List other eligible program and case number or attach documentation:

**Part 4: ALL OTHER HOUSEHOLDS:** Complete this part only if you did not complete sections #2 or #3. List all household members, including the child listed above. List all income. Go to section #5.

Names	Current MONTHLY Income			
	Names of household members (include the children listed above.)	Monthly Earnings from Work before deductions Job 1	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security
1.	\$	\$	\$	\$
2.	\$	\$	\$	\$
3.	\$	\$	\$	\$
4.	\$	\$	\$	\$
5.	\$	\$	\$	\$
6.	\$	\$	\$	\$
7.	\$	\$	\$	\$
8.	\$	\$	\$	\$
9.	\$	\$	\$	\$
10.	\$	\$	\$	\$
11.	\$	\$	\$	\$
12.	\$	\$	\$	\$

**Part 5: SIGNATURE AND SOCIAL SECURITY NUMBER:**

**PENALTIES FOR MISREPRESENTATION:** *I certify that all of the above information is true and correct and that the food stamp or TANF or other eligible program case number or documentation is current, correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds, that institution officials may verify the information on the Application for Free and Reduced-Price Meals, and that deliberate misrepresentation may subject me to Prosecution under applicable State and Federal laws.*

Signature of Adult: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
or an indication he/she has none

Printed Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date: \_\_\_\_\_

Are you a family day care home provider applying for Tier I benefits?  Yes  No

Section 9 of the National School Lunch Act requires that, unless a food stamp or TANF case number is provided for your child, you must include a social security number on the application. This must be the social security number of the adult household member signing the application. If the household member signing the application does not possess a social security number, he/she must indicate so on the application. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or TANF benefits, contacting the State employment security office to determine the amount of benefits received, and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigation violations of certain Federal, State, and local education, health, and nutrition programs.

**Part 6: RACIAL/ETHNIC IDENTITY:** You are not required to answer these questions. If you choose to do so:

Please mark one or more of the following racial identities:

American Indian or Alaska Native  Asian  Black or African American  White  Native Hawaiian or Other Pacific Islander

Please mark one of the following ethnic identities:

Hispanic or Latino  Not Hispanic or Latino

**Part 7: OTHER BENEFITS:** This application information may be shared with the Family and Social Services Administration for the purpose of determining children who may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. If you **DO NOT** want the application shared for this purpose, please sign below.

I certify that I am the parent/guardian of the child(ren) for whom application is being made. I **DO NOT** want the release of information for this purpose.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

For Information about Hoosier Healthwise health insurance, call **1-800-889-9949**.

*In the operation of child feeding programs and in accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call 202-720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.*

**FOR OFFICIAL USE ONLY:** Monthly Income Conversion: Weekly X 4.33 Every 2 weeks X 2.15 Twice a Month X 2

Food Stamp, TANF, or other eligible benefit program (for Tier II day care homes only)—Is the household categorically eligible for free/reduced meals?  Yes  No

Total Monthly Income: \_\_\_\_\_ Household Size: \_\_\_\_\_  Eligible  NOT Eligible

Eligibility Classification  Free  Reduced-Price  Paid  Tier I  Tier II

Temporary Approval:  Free  Reduced-Price  Tier I 45 day time period ends: \_\_\_\_\_

Printed Name and Title of Determining Official \_\_\_\_\_

Original Signature \_\_\_\_\_ Approval Date: \_\_\_\_\_

**THIS FORM EXPIRES ONE YEAR FROM THE APPROVAL DATE**