



Lead Program After-School Program Enrollment Agreement

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
School name		School address			Grade	School phone	

Family Information

Parent/Guardian		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Email						Work phone	
Employer	Employer address		City	State	Zip	Work hours	
Other Parent/Guardian		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Email						Work phone	
Employer	Employer address		City	State	Zip	Work hours	

Child Emergency Contact and Release Information *(do not include parents/guardians)*

Please notify the center if an Emergency Release Contact will pick up your child on a given day.

Person #1		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Person #2		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Person #3		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip

Authorized Pick-Up Persons *(if separate from Emergency Contacts)* [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.]

Name	Address	Phone Number
Name	Address	Phone Number
Name	Address	Phone Number

The persons designated in the Emergency Contact and Release 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. 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.

Special Pick-Up Instructions

[Biological/custodial parents must be given access to their children, unless there is a court order preventing it. A copy of the court order will be placed on file.]

Any individuals with court orders against them, therefore, preventing child pick-up may be listed below.

Name	Relationship to Child
Name	Relationship to Child
Other Restrictions on Child Pick-Up:	

Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks _____

Child's Medical & Developmental History

- Does your child have any special medical conditions? No Yes Explain _____
- Does your child have any chronic illnesses? No Yes Explain _____
- Please list a brief history of your child's serious injuries and hospitalizations. _____
- Does your child have diabetes? No Yes *If yes, please attach care instructions from your physician.*
- Does your child have asthma? No Yes *If yes, please attach care instructions from your physician.*
- Will medication need to be administered regularly? No Yes *If yes, personal arrangements will need to be made. Our staff will not be certified to administer medicine.*
- Does your child have any special dietary needs? No Yes Explain _____
- Is your child able to fully participate in all activities? Yes No Explain _____
- Does your child have any physical restrictions? No Yes Explain _____
- Does your child function at the level of other children in his/her age group? Yes No Explain _____
- Is your child able to walk Yes No _____
- Can your child communicate his/her needs? Yes No _____
- Does your child need assistance at meal time? No Yes Explain _____
- Does your child rest during the day? No Yes _____
- Is your child toilet trained? No Yes _____
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses, etc.? No Yes Explain _____
- Does your child require one-to-one care/supervision on a regular basis for a significant period of time? No Yes Explain _____
- 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 tract 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 Rubella _____	<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)

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 initial _____ Staff initial _____ Date _____

Parent initial _____ Staff initial _____ Date _____

Medical Information (continued)

Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone	
Physician's practice address	City	State	Zip
Preferred hospital/clinic for emergency care	City	State	

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)

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state.

Anthrax	Influenza	Pneumococcal disease	Smallpox
Diphtheria	Lyme Disease	Polio	Tetanus
Haemophilus Influenzae type b (Hib)	Measles	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	Mumps	Rubella	Varicella (Chickenpox)
Human Papillomavirus (HPV)	Pertussis (Whooping Cough)	Shingles (Herpes Zoster)	Yellow Fever

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 in accordance with state child care regulations.	Initial
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.	Initial
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.	_____

Special Permissions

I give my permission to this center to apply <input type="checkbox"/> sunscreen and <input type="checkbox"/> insect repellent to my child. <i>Please check which product you will permit.</i>	Initial
I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name.	_____
I have special instructions for the application process. <input type="checkbox"/> None <input type="checkbox"/> _____	_____

Parent initial _____ Staff initial _____ Date _____

Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Initial

Media Release

Occasionally, audio, photos, and video will be taken of the children at the center for use within the center, social media, or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Initial

Parent initial _____ Staff initial _____ Date _____

Other Agreements (continued)

Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center (e.g., Mitchell Stadium, City Park). **Initial**

Transportation (only available for Bluefield, Brushfork, and Bramwell area students)

I give my permission for LEAD Program to transport my child from school to the after-school facility. **Initial**

Arrival and Departure Procedures

Arrival

Child will be (please check one of the following)

- Dropped off by Parent/Guardian or Emergency Contact
- Dropped off by Public School Bus
- Walking from BMS (6th grade and older)

Departure

Child will be (please check one of the following)

- Picked up by Parent/Guardian or Emergency Contact
- Walking (6th grade and older)

Initial

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