



ENROLLMENT PACKET

Each of these forms is required for enrollment and must be turned in to the office no later than the week prior to enrollment.

The additional "Intake under 2 form" is required for any children under 2



ENROLLMENT CONTRACT

Child Information

Name	
Address	
City / State / Zip	
Date of Birth / Due Date	
Male / Female	
Program Applying For	
Start Date	

Parent / Guardian Information

Mother's Full Name	
Address	
City / State / Zip	
Home Phone	
Cell Phone	
Employer	
Work Address & Phone	
Email	

Father's Full Name	
Address	
City / State / Zip	
Home Phone	
Cell Phone	
Employer	
Work Address & Phone	
Email	

Enrollment Information

Full or Part time?	
Days (Check all that apply)	Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/>

Additional Information

How did you hear about LSA?	
-----------------------------	--

Tuition

Child's Name		Weekly Tuition	
Child's Name		Weekly Tuition	
Child's Name		Weekly Tuition	

Total:

I agree to pay the above tuition amounts weekly beginning on or before the Friday prior to the week of care. I acknowledge that the Registration Fee paid is non-refundable.

Have read and agree to all of the center policies and understand that I am to provide a 2 week written notice of intent to withdraw children and I am required to pay those two weeks whether or not children continue to attend.

I understand and agree to pay any fees applicable that are outlined on the second page of the rate sheet.

 Signature

 Date



WHAT TO BRING

Seedlings Classroom

Infants from 6 weeks- about 12/15 months

- Diapers (Cloth or Disposable)
- Baby Wipes
- Diaper Cream
- Labeled Blanket
- Swaddle Blanket with Velcro or Sleep Sac if used
- Labeled Pacifier
- 5 bottles
- 3 labeled full changes of clothes

Emergent Toddler Program

Young Toddlers from about 1-2 years old

- Diapers (Cloth or Disposable)
- Baby Wipes
- Diaper Cream
- Labeled Sleeping Bag & Blanket
- Comfort Item (ex. Stuffed animal) if used
- Pacifier if used
- 3 bottles if used
- 3 labeled full changes of clothes
- Sunscreen
- Insect repellent (DEET free)
- Outdoor play clothing suitable for season (Shade hat, coat, winter hat, mittens etc.)
- Labeled water bottle

Toddler Program

- Diapers or pull-ups, Wipes & Diaper Cream
- Labeled Sleeping Bag & Blanket
- Comfort item (ex. Stuffed animal) if used
- 3 full changes of clothes
- Sunscreen
- Insect repellent (DEET free)
- Outdoor play clothing suitable for season (Shade hat, rubber boots, coat, winter hat etc.)
- Backpack (large enough to fit their take-home folder)
- Program fee

Preschool Program

- Labeled Sleeping Bag & Blanket
- Comfort item (ex. Stuffed animal) if used
- 2 full changes of clothes
- Sunscreen
- Insect repellent (DEET Free)
- Outdoor play clothing suitable for season (Shade hat, rubber boots, coat, winter hat etc.)
- Backpack (large enough to fit their take-home folder)
- Program fee



HEALTH HISTORY AND EMERGENCY CARE PLAN

Child's Name	
Child's Birthday	

Sunscreen Authorization

I authorize the center to apply sunscreen to my child	Yes	No
Brand Name		
Ingredient Strength		

Insect Repellent Authorization

I authorize the center to apply repellent to my child	Yes	No
Brand Name		
Ingredient Strength		

Medical Conditions

Please check any special medical conditions that your child may have:

No specific medical conditions
Asthma
Cerebral Palsy/ Motor Disorder
Diabetes
Epilepsy/ Seizure Disorder
Gastrointestinal or feeding concerns including special diet and supplements
Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
Other condition(s) requiring special care- Specify:
Milk Allergy. If a child is allergic to milk attach a statement from the medical professional indicating the acceptable alternative
Food Allergies- Specify food(s):

Non-Food Allergies- Specify:

Triggers that may cause problems- Specify:

Signs or symptoms to watch for- Specify:

Steps the child care provider should follow:

(If prescription or non-prescription medications are necessary, a copy of the form Authorization to Administer Medication should be attached to this form)

Identify any child care staff to whom you have given specialized training/ Instructions to help treat symptoms:

- a.
- b.
- c.

When should parents be called regarding symptoms or failure to respond to treatment?

When should it be considered that the condition requires emergency medical care or reassessment?

Additional information that may be helpful to the child care provider:

Signature- Parent or Guardian

Date Signed (mm/dd/yyyy)

Review Dates: _____
(mm/dd/yyyy)



EMERGENCY CONTACT(S)

The top two individuals are typically the Mother & Father or legal guardians

Name	
Relationship to Child	
Address	
City/ State/ Zip	
Home or Cell Phone	
Work Phone	
Authorization to Pick up your Child?	

Name	
Relationship to Child	
Address	
City/ State/ Zip	
Home or Cell Phone	
Work Phone	
Authorization to Pick up your Child?	

Additional individuals Authorized to pick up your child with prior notice:

Name	
Relation to Child	

Name	
Relation to Child	

Name	
Relation to Child	

Name	
Relation to Child	



PHOTO RELEASE FORM

Little Sprouts Academy has permission to post my child, _____'s photo:

On the Little Sprouts Academy Facebook Page	<input type="checkbox"/> Yes	<input type="checkbox"/> No
On the Little Sprouts Academy Website	<input type="checkbox"/> Yes	<input type="checkbox"/> No
On Little Sprouts Academy's Instagram	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Signature

Date

CHILD HEALTH REPORT

Each child under 2 years of age shall have an initial health examination not more than 6 months prior to no later than 3 months after being admitted to the school and a follow-up health examination at least once every 6 months thereafter.

Children 2 years or older, who are not yet enrolled in Elementary school, shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to school and a follow-up health examination at least once every 2 years.

Parent/Guardian shall give this form to the physician to be completed, signed and dated. Immunization record form below can be filled out or immunizations may be stapled to this form.

PARENT OR GUARDIAN: Please fill out the following section:

Child's Name (First, Last, MI)	
Child's Birthday (mm/dd/yyyy)	
Child's Address (Street, City, State, Zip Code)	
Parent or Guardian Name (Last, First, MI)	
Parent/Guardian Address (Street, City, State, Zip)	

HEALTH CARE PROFESSIONAL: Please fill out the following sections:

Instructions for feeding and care of child with special health concerns, Specify (attach information if necessary)
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child have a milk allergy? If "yes", identify the recommended substitute
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the child have any food or non-food allergies? If "yes," specify/include treatment plan to be implemented in the event of allergic reaction
Date of child's most recent lead blood test: _____ (mm/dd/yyyy)
Immunizations not to be administered to child due to medical reason(s), Specify

AUTHORIZATION:

I certify that I have examined the above child on this date and that he/she is able to participate in child care/school activities.	
_____ Name- MD, PA or other HealthCheck Provider (type or print)	_____ Address (Street, City, State, Zip)
_____ Signature- MD, PA or other HealthCheck Provider	_____ Date of Exam:

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2	List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.					
	TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
	Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
	Polio					
	Hib (Haemophilus <i>Influenzae</i> Type B)					
	Pneumococcal Conjugate Vaccine (PCV)					
	Hepatitis B					
	Measles-Mumps-Rubella (MMR)					
	Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					
	Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known. <input type="checkbox"/> Yes year _____ (Vaccine is not required) <input type="checkbox"/> No or Unsure (Vaccine is required)					

REQUIREMENTS

STEP 3	The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.							
	AGE LEVELS	NUMBER OF DOSES						
	5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
	16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³	
	2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³	1 Varicella
	At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³	2 Varicella
	¹ If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable). ² If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required. ³ MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1 st birthday is also acceptable). ⁴ Children entering kindergarten must have received one dose after the 4 th birthday (either the 3 rd , 4 th or 5 th) to be compliant (Note: a dose 4 days or less before the 4 th birthday is also acceptable).							

COMPLIANCE DATA AND WAIVERS

STEP 4	IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR IF THE CHILD <u>DOES NOT</u> MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center). <input type="checkbox"/> Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child WITHIN ONE YEAR and to notify the child care center in writing as each dose is received. NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to \$25.00 per day of violation. <input type="checkbox"/> For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received) <div style="text-align: center;">_____ Physician's Signature Required</div> <input type="checkbox"/> For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received) <input type="checkbox"/> For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):
---------------	---

SIGNATURE

STEP 5	To the best of my knowledge, this form is complete and accurate.	
	SIGNATURE - Parent, Guardian or Legal Custodian	Date Signed