Steele School For Early Learning

5030 Carr Street, Arvada Colorado 80002

Lana
303 481-8653

Date of enrollment_______________

Child's Name________________________________Nickname_______________

Home Address____

Home Phone____________________Sex M F Age________Date of Birth_______________

Family Members:____

Mother or Guardian's

Name____

Address if different from the child's________________________________

Home Phone_______________Cell Phone_______________Email_______________

Name of employment (Mother)________________________________

Occupation____

Address of employment (Mother)________________________Work phone___________

Father or Guardian's

Name____

Address if different from the child's________________________________

Home Phone_______________Cell Phone_______________Email_______________

Name of Employment (Father)________________________________

Occupation____

Address of employment (Father)________________________Work phone___________

Special instructions for reaching parent or guardian________________________

Emergency contacts

1. Name____________________Home phone___________Cell phone___________

Address____

Work phone____________________Relationship to child____________________

2. Name____________________Home phone___________Cell phone___________

Address____

Work phone____________________ Relationship to child____________________

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CHILD PICK UP INFORMATION

Persons authorized to pick up your child MUST show a photo ID

Name____
Home Phone__________________Work Phone______________
Name____
Home Phone__________________Work Phone______________
Name____
Home Phone__________________Work Phone______________

Name, address and phone number of child's doctor

Name, address and phone number of child's dentist______________

Hospital of Preference:
Please be complete:
Name of Hospital:__________________________________
Address:____
PhoneNumber:____________________________________

Chronic Medical conditions ______________________________

Does your child have a health care plan?__________If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized?________complete immunization records must be provided on or before the first day the child is in care.

Food Allergies?______________________________________

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EMERGENCY INFORMATION & AUTHORIZATION FOR TREATMENT & TRANSPORTATION

Child's Name________________________Nickname________________Date of Birth____________

Home Address______________________________________Home phone____________________

Parent/Guardian______________________________Cell phone________________________

Employer____

Employer Address____

Parent /Guardian______________________________Cell phone________________________

Employer____

Employer Address____

Alternate Emergency contact:

1. Name______________________Relationship___________Phone#__________Cell #__________

Address____

2.Name______________________Relationship___________Phone#__________Cell#__________

Address____

Health Care Facility (must be provided)

Name__________________Address_______________________Phone Number_____________

Allergies or Restrictions____

Chronic Illness/Special needs____

Medications____

Insurance Information____

Authorization for emergency medical care and transportation:

In the event of an emergency I hereby give my permission for child care staff to access emergency medical services for my child, including transportation to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be make to locate me, and I accept the expense of care and transport.

Parent's signature________________________________Date_______________________

Parent's signature________________________________Date_______________________

Child Care facility: Steele School For Early Learning

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Health History

Health History
(Chronic or recurring)
Ear infections________________
Diabetes________________
Heart disease/defect__________
Convulsions/seizures__________
Asthma________________
Nosebleeds________________
Measles________________
Mumps________________
Chicken Pox________________
Flu or Flu shot________________

Allergies
(Nature of reaction)
Hay Fever________________
Plant Poisoning__________
Insect stings______________
Penicillin________________
Other drugs______________
Animals______________
Food________________
Other________________

Operations or serious injuries (dates)________________________________
Is the child on any medications? (explain)____________________________
If Yes Please describe____
Physical limitations____________Describe if Yes____________________
Dietary limitations____________Describe if Yes____________________
Vision____________________Hearing________________________
Are there any activities you would prefer your child NOT participate in?
If so please list:____

Authorization for Emergency Medical Care

I hereby give my permission to Steele School for Early Learning to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child.
Parent Signature________________________________Date____________

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment

Parent Guardian signatures
________________________________Date____________
________________________________Date____________

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Tuition and Fee agreement

Rates:

Infant age 6 weeks to 18 months.

Daily $75.00	Weekly $ 292.00	Monthly $1168.00

Toddlers 18 months till potty trained.

Daily $66.00	Weekly $253.00	Monthly $1011.00

Preschool ages 3—5

Daily $59.00	Weekly $225.00	Monthly $899.00

Before and after school

Before only	Daily $15.00	Weekly $60.00	Monthly $200.00
After only	Daily $ 20.00	Weekly $100.00	Monthly $360.00
Before and After	Daily $35.00	Weekly $150.00	Monthly $ 500.00

Annual fees are payable September 1 of each year. Registration fee $75.00 with a student insurance fee of $30.00 for a total of $105.00 yearly.

Tuition:

Tuition is always due in advance of the first day of attendance. We accept cash money orders and checks as well as VISA and Master card. The annual registration fee must be paid to start enrollment. If a student withdraws at any point the fee is non-refundable and non-transferable. Tuition is non refundable.

Child care hours:

The childcare center is in session Monday through Friday 7am to 5:30pm. Our doors open at 6:45 and close promptly at 5:45. Staff will stay with children until all are picked up. Parents who fail to pick up their child/children
By 5:45 will be charged a fee of $2.00 per minute/per child starting at exactly 5:46.**This fee will be payable in cash at time of pick up.** Frequent violations of this policy will result in termination and late fees will be charged from 5:30.

Rates:

Once you have chosen a payment plan (i.e. weekly or monthly) we ask that your remain on that schedule.

PLEASE NOTE

You are required to pay for the full number of days each week that your child is scheduled to attend. There is no reduction in tuition for holidays, absences, illness, or snow days.
Two weeks vacation is available to families after the first year of attendance: see parent handbook for details. Two weeks written notice is required.

I have read and agree to comply with the tuition guidelines above. I understand that non-payment of tuition as outlined is cause for termination of my child's enrollment.

Parents Signature________________________________SS#_____________________Date___________

Administration Signature____Date_________________

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Consent and Release

I hereby certify my consent and submission to all governing policies of the school. It is understood that the services of the school are engaged by mutual consent; and that, either I or the school reserves the right to terminate any or all services at any time. I agree to keep my tuition payments current and in accordance with Steele School policy. I understand and agree with the video and television policy of the school, which is stated in the parent handbook.

I authorize use of my child's photograph in any Steele School publication including but not limited to Steele School brochure, newsletters, and websites.

I, the undersigned give my permission for my child to participate in all activities sponsored by Steele School for Early Learning both on and away from campus.

Child's name____Date____________________

Parents signature____

Administrator signature_________________________________Date__________________

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Parental Authorization to administer topical medication

The parent/guardian of____ask that school staff give the

Following medication ____at______________________

to my child.

Topical ointment and medications may not be administered if skin is broken but only as a preventative.

Parent/guardian signature____

Date__________________ Daytime phone number_________________________

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STUDENT HEALTH RECORD

STUDENT NAME		DATE OF BIRTH	MONTH - DAY - YEAR
ADDRESS	CITY / STATE / ZIP		SEX ☐ M ☐ F
MOTHER'S NAME	FATHER'S NAME		

MEDICAL INFORMATION

CHECK ILLNESSES CHILD HAS HAD AND GIVE APPROXIMATE DATES						
	☐ RUBEOLA	☐ RUBELLA	☐ CHICKEN POX	☐ SCARLET FEVER	☐ MUMPS	☐ STREP THROAT
	☐ RHEUMATIC FEVER	☐ HAY FEVER	☐ DIABETES	☐ WHOOPING COUGH	☐ EPILEPSY	☐ POLIO MYELITIS
	☐ OTHER	☐ ASTHMA				

THIS CHILD IS PHYSICALLY OR EMOTIONALLY ABLE TO PARTICIPATE IN THE CHILDCARE / SCHOOL PROGRAM NAMED ABOVE. ☐ YES ☐ NO

PARTICIPATION IS APPROVED FOR ACTIVITY IN A PHYSICAL EDUCATION PROGRAM AND / OR AN ELEMENTARY SPORTS PROGRAM (I.E., SOCCER, BASKETBALL, ETC.) ☐ YES ☐ NO

CONTACT WITH T.B? ☐ YES ☐ NO | TUBERCULIN TEST GIVEN? ☐ YES ☐ NO | RESULTS OF T.B. SKIN TEST

ANY SURGERIES OR ACCIDENTS? ☐ YES ☐ NO | EXPLAIN

OTHER ILLNESSES OR SPECIAL PROBLEMS? ☐ YES ☐ NO | EXPLAIN

MEDICATIONS PRESCRIBED:

PHYSICAL FINDINGS:

VISION (IF TESTED): | HEARING (IF TESTED)

SPECIAL INFORMATION

DRUG REACTIONS? ☐ YES ☐ NO | EXPLAIN

ALLERGIES? ☐ YES ☐ NO | EXPLAIN

SPECIAL DIET? (EXPLAIN)

DESCRIBE ANY PHYSICAL CONDITION REQUIRING SPECIAL ATTENTION BY STAFF:

RECOMMENDATIONS AND COMMENTS TO SCHOOL PERSONNEL:

DATE OF MY MOST RECENT EXAMINATION OF THIS CHILD:

PLEASE PRINT

NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF DENTIST
PHONE NUMBER	PHONE NUMBER
Signature of Physician or Nurse Practitioner Date	

PLEASE RECORD IMMUNIZATIONS AND DATES ADMINISTERED ON THE COLORADO DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION AND ATTACH TO THIS FORM (IF APPLICABLE).