

STEELE SCHOOL FOR EARLY LEARNING

5030 Carr Street
Arvada, CO 80002
303-431-5653

Date of Enrollment: _____

Child's Name _____ Nickname _____

Home Address: _____

City _____ State: _____ Zip Code: _____

Home Phone: _____ Sex: M F Age: _____ DOB _____

Family Members: _____

Mother or Guardian's:

Name: _____

Address if different from child's: _____

Home Phone: _____ Cell: _____

Email address: _____

Name of employment: _____

Occupation _____

Address of employment: _____

Work Phone: _____

Father or Guardian's:

Name: _____

Address if different from child's: _____

Home Phone: _____ Cell: _____

Email address: _____

Name of employment: _____

Occupation _____

Address of employment: _____

Work Phone: _____

Special instructions for reaching parent or guardian: _____

Emergency Contacts

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

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EMERGENCY INFORMATION & AUTHORIZATION FOR TREATMENT & TRANSPORTATION

Child's Name _____ Date of Birth _____

Home address _____

City _____ State _____ Zip code _____

Parent/Guardian _____

Home Phone _____ Cell _____ Work _____

Employer _____ Address _____

Parent/Guardian _____

Home Phone _____ Cell _____ Work _____

Employer _____ Address _____

Alternate Emergency Contact

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Health care facility (must be provided)

Name _____

Address: _____

Allergies or restrictions _____

Chronic illness/special needs _____

Medications _____

Insurance information _____

AUTHORIZATION FOR EMERGENCY 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 conscience effort will be made to locate me, and I accept the expense of care and transport.

Parent/guardian signature _____ Date _____

Parent/guardian signature _____ Date _____

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Child's name _____

CHILD PICK UP INFORMATION

Persons authorized for pick up MUST show a photo ID

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Name _____ Home Phone _____ Cell _____

Address _____

Work phone _____ relationship to child _____

Name, address and phone number of child's doctor _____

Name, address and phone number of child's dentist _____

Hospital of preference (must be complete)

Name _____ Address _____

City _____ State _____ Zip _____

Phone number _____ - _____

Chronic Medical Conditions Yes or No. explain _____

Does your child have a health care plan? YES or NO. If yes explain _____

Is your child fully immunized? YES or NO. Must provide complete immunization records on first day of care.

Food allergies? _____

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Child's name _____

Health History

Chronic or reoccurring/nature of reaction

Health History

Ear infections _____
Diabetes _____
Heart disease/defect _____
Convulsion/seizures _____
Asthma _____
Nosebleeds _____
Measles/mumps _____
Chicken pox _____
Flu or flu shot _____

Allergies

Hay fever _____
Plant poisoning _____
Insect Sting _____
Penicillin _____
Other drugs _____
Animals _____
Food _____
Other _____

Operations or serious injuries (dates) _____

Is the child on any medications? YES or NO. if yes, explain _____

Physical limitations? YES or NO. if yes, explain _____

Dietary limitations? YES or NO. if yes, explain _____

Vision _____ Hearing _____

Are there any activities you would prefer your child NOT participate in? if yes, explain _____

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/guardian signature _____ date _____

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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PARENTAL AUTHORIZATION TO ADMINISTER TOPICAL MEDICATION

The parent/guardian of _____ ask school staff give the following medication
_____ at _____ to my child.

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

Parent/Guardian _____

Date _____ Daytime Phone _____

PARENTAL AUTHORIZATION TO ADMINISTER TOPICAL MEDICATION

The parent/guardian of _____ ask school staff give the following medication
_____ at _____ to my child.

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

Parent/Guardian _____

Date _____ Daytime Phone _____

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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 have received a copy of the parent handbook location on www.arvadapreschool.com and acknowledge it is my responsibility to read this and understand its contents.

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 understand and give 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 _____

Parent's signature _____

Administrator signature _____

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Rates:

6 weeks-18 months

Daily- \$79 Weekly-\$307 Monthly- \$ 1227

19 months- Potty Trained*

Daily- \$69 Weekly-\$266 Monthly- \$ 1062

Potty Trained- School age

Daily- \$62 Weekly-\$237 Monthly- \$ 944

Once you have picked a payment schedule (daily, weekly, bi-monthly, or monthly) we ask that you remain on that schedule. Please circle your choice of payment schedule. If this needs to change please see administration.

Registration fees:

Registration fees are due upon registration to secure your spot, and then annually on September 1st. The registration fee is \$80 with a student insurance fee of \$40 for a total of \$120. This fee is non-refundable.

Tuition:

Tuition is due on or before the first day of attendance. We accept cash, money order, check, or credit card (except American Express). Tuition is non refundable and non transferable.

Hours:

We are open Monday - Friday from 7am- 5:30 pm. Parents who fail to pick up your child/ children by 5:30 will be charged a late fee of \$2.00 per minute, per child. **This fee is payable in cash the next day.** If the late fee is not paid within 2 days this may result in suspension of care.

Attendance:

You are required to pay for the full number of days your child is scheduled to attend. This includes sick days, snow days, holidays, and teacher training days that occur on your child's scheduled days.

My child _____ will be attending these days (circle all that apply)
Monday Tuesday Wednesday Thursday Friday

Vacation:

Up to one week of vacation is offered to families after 1 year of continuous enrollment. Two week written notice is required to use these days. Please see parent handbook for further details.

Discounts: (circle answers) Military discount? Y/N Service job discount? Y/N Sibling discount? Y/N

* Potty-trained is defined as 2 weeks clean and dry. See parent handbook for further details.

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

Parent signaure _____ SSN _____ Date _____

Administration signaure _____ Date _____

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: _____ Birthdate: _____

Allergies: None or Describe _____
Type of Reaction _____

Diet: Breast Fed Formula _____ Age Appropriate
 Special Diet _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ DATE: _____

Parent/Guardian Signature _____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ Weight @ Exam: _____

Physical Exam: Normal Abnormal (Specify any physical abnormalities) _____

Allergies: None or Describe _____ Type of Reaction _____

Significant Health Concerns: Severe Allergies Reactive Airway Disease Asthma Seizures Diabetes Hospitalizations
 Developmental Delays Behavior Concerns Vision Hearing Dental Nutrition Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: None or Describe _____
Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed
Dose _____ or see the attached age-appropriate dosage schedule from our office

OR Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed
Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: Up-to-Date See attached immunization record Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level Not at risk or Level _____**

****TB Not at risk or Test Results Normal Abnormal**

****Screenings Performed: Vision: Normal Abnormal Hearing: Normal Abnormal Dental: Normal Abnormal-**

Recommended Follow-up _____

Provider Signature

Next Well Visit: Per AAP guidelines* or Age _____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp
Or write Name, Address, Phone, #
