

**ENROLLMENT AGREEMENT
THE TRAINING STATION NURSERY SCHOOL REGISTRATION**

Class Preference: _____ Amount _____ Check# _____ Cash _____

CHILD'S NAME _____ AGE _____

BIRTHDAY _____ SEX _____ PHONE _____

MOTHER'S NAME _____ FATHER'S NAME _____

MAILING ADDRESS _____

CITY, STATE, ZIP _____

EMAIL ADDRESS _____

LIABILITY STATEMENT

I know of no reason, health or otherwise, why _____ should be restricted from this program. I agree to hold the Training Station Nursery School, director and staff harmless for any accident.

Signature of parent or guardian: _____ Date: _____

PAYMENT AGREEMENT

I understand that my payment agreement is as follows:

1. REGISTRATION: An annual fee based upon the number of days attending is due and payable on the day of registration.
2. DEPOSIT: Upon registration you will pay a non-refundable deposit covering May's tuition (last month of the school year attending).
3. TUITION: Tuition is based on a yearly fee, but may be made in monthly payments equal to 9 payments. September's payment is due upon entering school. Payment is due by the 1st of the month and late payments are subject to a \$10.00 late fee per week that it is late. Tuition is not adjusted for vacation periods, inclement weather, absenteeism and there are no makeup days in the schedule.
4. METHODS OF PAYMENT: Payment may be made by checks, money order, cash, or credit card. There is a 5% convenience fee added to credit card payments. There will be a \$35 fee for returned checks. The Training Station will not be responsible for any payment lost, stolen or mislaid before delivery to the center.
5. REFUND POLICY: **All deposits are non-refundable.** Written notice of withdrawal must be received before **July 15th** of year enrolled. If notice is not received by July 15th, **September tuition will be due in full.**

I give permission for the school to use my child's photo for publicity purposes & for news items: Yes _____ No _____

I give permission for my address/phone number to be distributed to parents enrolled in this school: Yes _____ No _____

I have been informed about A Parent's Guide To Regulated Child Care found at www.marylandpublicschools.org

I have read the payment agreement and hereby agree to accept the terms and conditions as stated above.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

Training Station Fees and Tuition 2019-2020

First Steps (All 2's classes) (2 days per week)

monthly tuition \$275

Total for year \$2475

5% discount if paid in full before
September 15th. Save \$123.75

Total pre-paid tuition \$2351.25

3's A.M. (3 days per week)

monthly tuition \$375

Total for year \$3375

5% discount if paid in full before
September 15th. Save \$168.75

Total pre-paid tuition \$3206.25

3's P.M. (4 days per week)

monthly tuition \$385

Total for year \$3465

5% discount if paid in full before
September 15th. Save \$173.25

Total pre-paid tuition \$3291.75

Pre-K (5 days per week)

monthly tuition \$425

Total for year \$3825

5% discount if paid in full before
September 15th. Save \$191.25

Total pre-paid tuition \$3633.75

Registration:

Fees due at registration include one month's tuition PLUS an annual fee determined by the number of days per week attending.

2 Days—\$75

3 Days—\$90

4 Days—\$105

5 Days—\$120

Policies Concerning Fees and Tuition

- ⇒ Families with 2 or more children enrolled enjoy a price break of \$10 per child per month. This discount may not be used if you are paying in full prior to September 15th and receiving a 5% discount for early payment.
- ⇒ Families who pay tuition in full prior to September 15th will receive a 5% tuition reduction. This discount may not be used in conjunction with the 2 or more children monthly discount.
- ⇒ One month's non-refundable tuition plus an annual fee is collected with registration (applied to the last month of the school year). September's payment is due upon entering school in September.
- ⇒ Members of the clergy and families who regularly attend CrossWay Church receive a tuition reduction of 10% per child enrolled. Families who regularly attend CrossWay Church are given priority in regards to enrollment.
- ⇒ Tuition is not adjusted for vacation, inclement weather, absenteeism, and there are no make up days on the schedule.
- ⇒ Tuition is due by the 1st of each month and a \$10 late charge is due each week that payment is late. Please note that we are always willing to work with you if you need to make payments on a different schedule than the one outlined. However, it is REQUIRED that you speak with the Director if you are unable to make payments as scheduled. Failure to make alternate payment arrangements with director could result in dismissal from the program.
- ⇒ There will be a \$35 penalty fee for returned checks
- ⇒ Refund policy: **All deposits are non-refundable, no exceptions will be made.**

HEALTH INVENTORY

CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

Child's Name _____	_____	_____	_____	_____
_____	Last	First	Middle	Birth Date
Name of Parent or Guardian _____	_____			Relationship _____
Home Address _____	_____			
City _____	State _____	Zip Code _____	_____	
Check Best Telephone Number to Reach You:				
<input type="checkbox"/> Home #: _____	<input type="checkbox"/> Work #: _____	<input type="checkbox"/> Cell #: _____	_____	

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.

PLEASE RETURN THIS COMPLETED FORM TO:

Name of Child Care Facility: _____

Address: _____

City/Town State Zip Code

PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

To be completed by **PARENT/GUARDIAN**

CHILD'S NAME: _____

IMPORTANT: COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health (<i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i>)?	_____	_____
2. Does your child have any eye problems (<i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i>)? Date of last eye examination: ____/____/____ Doctor's Name: _____ Results: _____ Does your child wear glasses? _____ Contact lenses? _____	_____	_____
3. Does your child have any ear or hearing problems (<i>frequent earaches, difficulty hearing, etc.</i>)? Date of last hearing evaluation ____/____/____ Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	_____	_____
4. Does your child have any speech problems (<i>difficulty having speech understood, stammering, delayed speech development, etc.</i>)?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: (a) Does this condition require any special health care in the child care facility? _____ (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? _____ (c) Does your child require any special adaptations or adaptive equipment? _____	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about?	_____	_____
8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about?	_____	_____

REMARKS (*Provide further explanation for all "YES" answers*): _____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature of Parent/Guardian

Date

PART II: MEDICAL INFORMATION

To be completed by a **HEALTH PRACTITIONER**

CHILD'S NAME: _____

1. Date of this child's most recent tuberculin test: ___/___/___ Result: ___ Positive ___ Negative

Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS) _____

- a. Vision problem YES NO _____
- b. Hearing problem YES NO _____
- c. Speech or language problem YES NO _____
- d. Other physical illness or impairment YES NO _____
- e. Mental, emotional or behavior problems YES NO _____
- f. Developmental delays YES NO _____
- g. Allergies YES NO _____

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care. YES NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO

If YES, please specify: _____

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs? _____

8. Does this child's physical activity need to be restricted? YES NO

If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO

If YES, please specify type: _____

Special instructions for use: _____

RECORD OF IMMUNIZATIONS

Vaccine Types												
Enter: Month/Day/Year for each immunization administered												
Dose #	DTP-DTAP	Polio	HIB	Hep B	PCV7	MMR	Varicella	Rotavirus	MCV4	HPV	Hep A	Other
1												
2												
3												
4												
5												

PART II: MEDICAL INFORMATION (CONTINUED)

Child's Name _____

MEDICAL CONTRAINDICATION: The above child has a valid medical contraindication to being immunized at this time. This is a permanent temporary condition until ____/____/____. Check appropriate box, indicate vaccine(s) and reasons: _____

HEALTH PRACTITIONER'S STATEMENT: To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS / IS NOT** medically cleared to attend child care.
 (circle correct response)

Signature of Health Practitioner **Date** **Phone Number**

STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. **If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS	<u>Baltimore (cont)</u>	<u>Carroll</u>	<u>Frederick(cont)</u>	<u>Montgomery</u>	<u>Prince George's(cont)</u>	<u>St. Mary's</u>
BY	21210	21155	21783	20783	20782	20606
ZIP CODE	21212	21757	21787	20787	20783	20626
	21215	21776	21791	20812	20784	20628
<u>Allegany</u>	21219	21787	21798	20815	20785	20674
ALL	21220	21791		20816	20787	20687
	21221		<u>Garrett</u>	20818	20788	
<u>Anne Arundel</u>	21222	<u>Cecil</u>	ALL	20838	20789	<u>Talbot</u>
20711	21224	21913		20842	20791	21612
20714	21227		<u>Harford</u>	20868	20792	21654
20764	21228	<u>Charles</u>	21001	20877	20799	21657
20779	21229	20640	21010	20901	20912	21665
21060	21234	20658	21034	20910	20913	21671
21061	21236	20662	21040	20912	20913	21673
21225	21237		21078	20913		21676
21226	21239	<u>Dorchester</u>	21082		<u>Queen Anne's</u>	
21402	21244	ALL	21085	<u>Prince George's</u>	21607	<u>Washington</u>
<u>Baltimore</u>	21250		21130	20703	21617	ALL
21027	21251	<u>Frederick</u>	21111	20710	21620	
21052	21282	20842	21160	20712	21623	<u>Wicomico</u>
21071	21286	21701	21161	20722	21628	ALL
21082		21703		20731	21640	
21085	<u>Baltimore City</u>	21704	<u>Howard</u>	20737	21644	<u>Worcester</u>
21093	ALL	21716	20763	20738	21649	ALL
21111		21718		20740	21651	
21133	<u>Calvert</u>	21719	<u>Kent</u>	20741	21657	
21155	20615	21727	21610	20742	21668	
21161	20714	21757	21620	20743	21670	
21204		21758	21645	20746		
21206	<u>Caroline</u>	21762	21650	20748	<u>Somerset</u>	
21207	ALL	21769	21651	20752	ALL	
21208		21776	21661	20770		
21209		21778	21667	20781		
		21780				

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child (daily) _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

INSTRUCTIONS TO PARENT:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____)_____
Telephone Number