ADMISSION INFORMATION

Operation Name	Director's Name	
Creative Minds Extended Day Program @ St. Theresa	Aurora Haller	
Child's Full Name	Child's Date of Birth	Child's Home Telephone No.
Child's Home Address		
Date of Admission / Date of Withdrawal		
Parent's or Guardian's Name	Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached: | Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES:

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ None ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____
Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.
3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.
4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ _____
Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian Date

"No Limits to Learning"

St. Theresa Extended Day Program
STUDENT DATA SHEET

School Year _____

CONTACT INFORMATION

Child's Name: _____ Date of Birth: _____

Mother's Name: _____

Address: _____ City: _____ Zip: _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Father's Name: _____

Address: _____ City: _____ Zip: _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Parent to Contact First: _____ ***Phone:*** _____

HEALTH INFORMATION

Allergies: _____ Documents attached: _____

Physician's Name: _____ Phone Number: _____

Hospital Name: _____ Phone Number: _____

EMERGENCY INFORMATION *(Other than parents)*

Emergency Contact Name: _____

Home Phone: _____ Work Phone: _____

AUTHORIZED PERSONS TO PICK-UP *(Other than parents)*

Name: _____ DL# _____

Name: _____ DL# _____

Name: _____ DL# _____

Name: _____ DL# _____

_____ _____

Parent/Guardian Signature Date

Creative Minds Extended Day Program
St. Theresa Catholic School

Extended Day Program - $45—Registration Fee for one child
$73—Registration Fee for two or more children
(This fee is non-refundable)

5 days AM & PM - $93 weekly
5 days AM only - $43 weekly
3 days AM & PM - $73 weekly
3 days AM only - $27 weekly
3 days PM only - $57 weekly

Tuition must be "paid in advance" on a monthly basis through our ProCare system (electronic transfer) only. Payment will be automatically deducted every first of the month. Non-school days (holidays, spring break, teacher in service training, etc.) will automatically be discounted.

ADDITIONAL FEES

Late Pick up of students	**$3 per minute starting at 6:30 p.m. must be paid by CASH ONLY upon picking up a student.**
Emergency use of Extended Day program	**$30 per day for AM and PM only.** **$20 per day for PM only.** **CASH PAYMENT ONLY**

Emergency use of the Extended Day Program will be permitted up to 3 times. After this, the student must be registered to use the Extended Day Program.

Tuition® Express

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) Creative Minds Child Development Center to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card- DEBIT ONLY)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

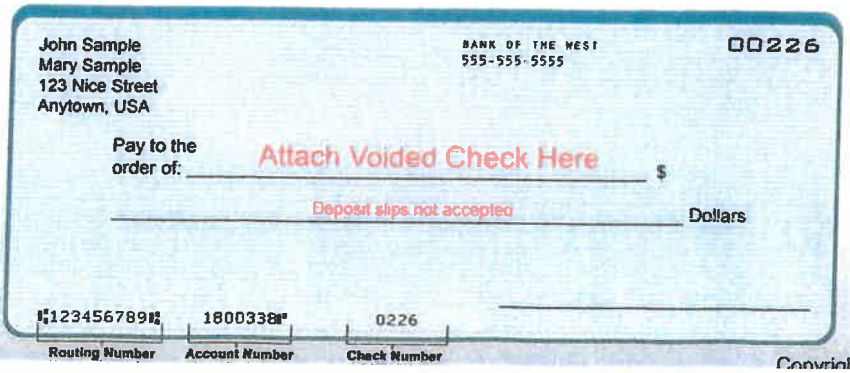
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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