



Children's Learning Center at Mitchell College REGISTRATION & ENROLLMENT FORM 2022-23

Current Date: _____ Anticipated Enrollment Date: _____
Child's Name (First, Middle, Last): _____ Nickname: _____
Name to be called at school: _____ Gender: M/F/Nonbinary Date of Birth: _____
Child's Physical Address: _____ State: _____ Zip Code: _____

Information to be completed by parent/guardian. **ANY revisions or a change of information requires a revised form.**

PARENTS/GUARDIANS/SPONSORS:

This form requires both parents'/guardians'/sponsors' information unless child is in the custody of only one parent, etc. A copy of custody papers is required to be on file at the Children's Learning Center.

All information must be filled out. If it is not applicable please write N/A.

Parent/Guardian/Sponsor: _____

Home Address: _____

City/State: _____ Zip code: _____

Work Phone #: _____ Cell Phone #: _____ Home Phone #: _____

Driver License Number: _____ Email address: _____

Employer: _____

Employer Address: _____ City/State: _____

Parent/Guardian/Sponsor: _____

Home Address: _____

City/State: _____ Zip code: _____

Work Phone #: _____ Cell Phone #: _____ Home Phone #: _____

Driver License Number: _____ Email address: _____

Employer: _____

Employer Address: _____ City/State: _____

Local Emergency Contact – (Two contacts required)

Full Name _____ Relationship to child: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone#: _____

Full Name _____ Relationship to child: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone#: _____

ADDITIONAL PEOPLE AUTHORIZED TO PICK UP CHILD FROM CENTER: (Photo I.D. Required)

Full Name _____ Relationship to child: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone#: _____

Full Name _____ Relationship to child: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone#: _____

Full Name _____ Relationship to child: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone#: _____

PERSONS UNAUTHORIZED TO PICK UP CHILD:

Full Name: _____
Brief Description: _____

Full Name: _____
Brief Description: _____

Would you like to provide photo for file ____yes ____no

CULTURAL DEMOGRAPHICS:

Is your child Hispanic/Latino? Yes ____ No ____ Prefer not to disclose ____

Race (check all that apply): American Indian or Alaskan Native ____ Asian American ____

Black or African American ____ Native Hawaiian or Other Pacific Islander ____ White ____ Prefer not to disclose ____

ADDITIONAL INFORMATION:

Is your child toilet trained? Yes ____ No ____

Does the child have any special medical condition, allergies, or needs? Yes ____ No ____

If yes, please describe:

Does the child have any identified special educational needs? Yes ____ No ____ If yes, please describe:

Has your child received Birth to three ____yes ____no

Any concerns that you would like to share with us regarding your child's development? ____yes ____no

Would you like schedule a meeting to discuss? ____yes ____no

Are there other children in the household?

Name: _____ DOB _____ RELATIONSHIP _____

Name: _____ DOB _____ RELATIONSHIP _____

Name: _____ DOB _____ RELATIONSHIP _____

What language did the child learn to speak first? _____

What is the primary language spoken in the child's home? _____

What other information regarding your child's life experiences can you share that will allow us to meet your child's needs? Is there anything else you think we should know about the child? (Special interests, experiences, home life, etc.)

PHOTO/MEDIA RELEASE

I give approval to use pictures/video taken of my child for publicity or advertisements including internet based products and promotions. ____yes ____no **Initial** _____

I give approval to use pictures/video taken of my child for the bulletin boards and special projects in the classroom. ____yes ____no **Initial** _____

I give approval to upload pictures/videos taken of my child to the school Google Photo album for all families enrolled in the school to view. ____yes ____no **Initial** _____

PARENT HANDBOOK & BEHAVIOR/DISCIPLINE POLICY

I acknowledge receiving the family handbook (on website) and will abide by the policies that are written to help maintain a quality experience for my child. **Initial** _____

I have read and understand the CLC's Behavior & Discipline Policy, as outlined in the family handbook. **Initial** _____

WALKING PERMISSION SLIP

I give permission for my child to participate in walking field trips around the area of Mitchell College Children's Learning Center, including the Mitchell Woods, Mitchell Beach, and Toby May Park. **Initial** _____

SHARING CONTACT INFORMATION

May we add your e-mail address to our class list to be shared with other families in your child's class? ____yes ____no

How did you hear of us?

Is there someone we can thank?

Name: _____ Email: _____

DAYS AND TIMES MY CHILD WILL ATTEND

. The Children’s Learning Center at Mitchell College is open Monday through Friday from 7:00 a.m. until 5:00 p.m.

Regular operating hours for full day are 8:00 a.m. to 4:00 p.m.

Tuition: \$250 paid weekly. Before care and after care is available for \$15 per session per day.

Regular operating hours for half day 8:00 a.m. to 1:00 p.m

Tuition: \$180 paid weekly. Before care is available for \$15 per day.

Please consult the current calendar for holidays and closures. There is no reduction in tuition as a result of center closures. .

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on the Mitchell College website. If the college is closed due to weather conditions so will the CLC. If it becomes necessary to close early, we will contact you or someone listed in the Emergency Contact and Release, and it will be your responsibility to arrange for your child’s early pick up.

- My child will be attending full day - 8:00-4:00
- My child will be attending ½ day – 8:00-1:00
- My child will need before care from 7:00 am -8:00 am (additional \$15)
- My child will need after care from 4:00 pm – 5:00 pm (additional \$15)

| Days | Monday | Tuesday | Wednesday | Thursday | Friday |
|----------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Drop off | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. |
| Pick up | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. | _____ a.m./p.m. |

RATES

\$250 per week per child for Full Day (8am-4pm, M-F)

\$180 per week per child for Half Day (8am-1pm, M-F)

\$15 for before care/\$15 for after care

10% discount for more than one child; discount applied to higher priced tuition

Your account will be charged a two-week deposit. The initial deposit, securing your spot, will be charged the **first week of July**; the second week of the deposit will be charged the **third of week of August**. This is a non-refundable deposit but will be credited back to your account at the end of the school year to pay your last two weeks of tuition. **Initial**_____

Tuition is due and payable weekly by Thursday at 4:00 PM. **Initial**_____

A late fee of \$25 will be added to your tuition for payments received after 4:00 PM on Thursday. **Initial**_____

Tuition is not subject to discounts for holidays, emergency closures (i.e. weather or pandemics), or absence other than hospitalization. **Initial**_____

I agree to pay the tuition one week in advance of services rendered.

Initial _____

I agree to pay the full tuition fee even if my child is absent for one or more days.

Initial _____

I have the option to enroll in "autopay" through Brightwheel and tuition will be automatically deducted from my bank account or charged to my credit card .

Initial _____

A non-refundable registration fee of \$50 is due upon registration. Checks are made payable to "The Children's Learning Center at Mitchell College".

Initial _____

A \$40.00 materials fee will be added to your initial first week deposit. This materials fee covers some of the cost of, art materials, classroom basics, tissues, baggies, and enrichment activities throughout the year

Initial _____

A late pick up fee of \$1 per minute per child (not to exceed \$10 per child) is due if my child is not picked up by closing or 1:00 PM in the case of half day enrollment.

Initial _____

Accounts two weeks in arrears need to be addressed with the director.

Initial _____

All returned checks or ACH transactions (automatic debits) will be charged a fee of \$20.

Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status. Initial _____

A two week written notice is required for any child being withdrawn from the program.

Failure to provide notice in writing will result in forfeiture of deposit.

Initial _____

A receipt for income tax purposes will be provided automatically through Brightwheels.

Initial _____

To complete your child's enrollment, complete the following documents, included in this registration form, and submit all forms with a non-refundable \$50 registration fee to:

Children's Learning Center at Mitchell College
437 Pequot Avenue
New London, CT 06320

Checks made payable to Children's Learning Center at Mitchell College with "2021/2022 Enrollment" in Memo.

REQUIRED DOCUMENTS –

HEALTH RECORDS

Your child’s most recent physical exam, Health Assessment Record, and record of immunizations, completed by a healthcare professional, must be submitted with this registration form in order to enroll.

Health Assessment Record for children under the age of 5 can be found here: https://portal.ct.gov/-/media/SDE/School-Nursing/Forms/EC_HAR.pdf. Your child is also required to have a flu shot by December 31st of that school year unless they have a medical exemption.

EMERGENCY MEDICAL INFORMATION & CONSENT

***Parent/guardian is responsible for providing an updated form when information changes.**

Note any allergies or pertinent health conditions that emergency personnel should know (Bee Stings, allergies, asthma, medications s/he is taking, diabetes, etc.).

I understand that if my child is allergic to anything requiring the use of an Epi-Pen, I must bring an Epi-Pen to the Children’s Learning Center to keep onsite and have an **Authorizaton for Administration of Medicine Form** on file. Your child will not be able to attend school until this is in place and current. **Initial** _____

PHYSICIAN INFORMATION

Child’s Physician: _____ Phone: _____

Child’s Dentist: _____ Phone: _____

Preferred Hospital: _____

INSURANCE INFORMATION

Insurance Name: _____ Name Insured Under: _____ Insurance

Identification Number: _____ Insurance Phone #: _____

PERMISSION TO SEEK CARE

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention. I understand the camp staff are trained in the basics of First Aid and I authorize them to give my child First Aid. Initial _____

I also hereby authorize the Children’s Learning Center at Mitchell College personnel to call an emergency ambulance (at the parent/guardian(s) expense) in event of accident or acute illness, and to arrange for necessary and emergency care such as x-ray, examinations, anesthetic, medical, or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general statute of special supervision, and on the advice of any physician or surgical licensed to practice in the State of Connecticut when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful. It is understood that conscientious effort will be made to notify me (us) before such action will be taken. Initial _____

I hereby absolve the Children’s Learning Center at Mitchell College and Mitchell College of any and all liability claims, courses of action, or expenses, including any attorney fees, and any and all medical expenses. I understand that I am responsible for providing revisions to the information provided on the emergency information form as needed. Initial _____

Parent/guardian signature: _____ Date: _____

Parent/guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS STAFF

This type of authorization is limited to the following topical medications:

- 1. Ointments free of antibiotic, antifungal or steroidal medications (including sunscreen)
- 2. Medicated powders
- 3. Lip medications

Please choose one or more of the following:

- I will supply the program with the **sunscreen** listed below, in the original container and labeled with the child’s name.
- I will supply the program with the **insect repellent** listed below, in the original container and labeled with the child’s name.
- I will supply the program with another non-prescription topical medication in the original container labeled with the child’s name, name of the medication, and the directions of the medication administration, as described below.

SUNSCREEN

Name of Child: _____ Date of Birth: _____

Name of Topical Medication: _____

Schedule of Administration: _____ Site of Administration: skin

Medication shall be administered from: _____ / _____ / 2022 to: _____ / _____ / 2023

INSECT REPELLENT

Name of Child: _____ Date of Birth: _____

Name of Topical Medication: _____

Schedule of Administration: _____ Site of Administration: skin

Medication shall be administered from: _____ / _____ / 2022 to: _____ / _____ / 2023

OTHER

Name of Child: _____ Date of Birth: _____

Name of Topical Medication: _____

Schedule of Administration: _____ Site of Administration: skin

Medication shall be administered from: _____ / _____ / 2022 to: _____ / _____ / 2023

I give permission to allow the CLC staff to apply the above listed topical medications to my child.

Signature: _____ Relationship to child: _____

Address: _____ Telephone: _____

Staff to complete:

Parent authorization form and medication received by:

Staff Name: _____ Staff Signature: _____

Parent permission and medication administration record shall become part of the child's health record when the medication has ended.

MEDICAL ADMINISTRATION AUTHORIZATION

Authorization for the Administration of Medication by Child Day Care Personnel In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations.

Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed.

Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? ___yes ___no

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? ___yes ___no

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

____I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects.

____I request that medication be self-administered to my child as described and directed above.

Name of Child Care Program _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____ Relationship to
Child: ___ Mother ___ Father ___ Guardian/Other Explain: _____
Address _____ Town _____ Phone Number (____) _____
Signature of Parent/Guardian Authorizing Administration of Medication _____
Name of Childcare Personnel Receiving Written Authorization and Medication _____
Title/Position _____ Signature (in ink) _____