Children's Learning Center at Mitchell College

REGISTRATION & ENROLLMENT FORM 2023-24

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.

Full Day: Regular operating hours are 8:00 a.m. to 4:00 p.m.

- Tuition: $275 paid weekly. Before care and after care is available for $15 per session per day.

Half Day: Regular operating hours 8:00 a.m. to 12:00 p.m. *(Limited # of spots per class per year)*

- 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 – 8:00-12:00
- □ 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)

Please indicate below the expected schedule for your child including before/after care (if applicable):

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

$275 per week per child for Full Day (8am-4pm, M-F)

$180 per week per child for Half Day (8am-12 pm, 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______**

I agree to pay Tuition **one week in advance of services** rendered 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 full tuition fee even if my child is absent for one or more days. **Initial______**

I have the option to enroll in "autopay" through Procare 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 is due if my child is not picked up by closing or 12:00 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 $30.
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 ProCare. **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 "2023/2024 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 **Authorization 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: ______/______/ 2023______ to: ______/______/ 2024______

INSECT REPELLENT

Name of Child: ______________________________ Date of Birth: ____________

Name of Topical Medication: ______________________________

Schedule of Administration: ____________________ Site of Administration: ___skin___________

Medication shall be administered from: ______/______/ 2023______ to: ______/______/ 2024______

OTHER

Name of Child: ______________________________ Date of Birth: ____________

Name of Topical Medication: ______________________________

Schedule of Administration: ____________________ Site of Administration: ___skin___________

Medication shall be administered from: ______/______/ 2023______ to: ______/______/ 2024______

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

Signature: ______________________________ Relationship to child: __________

Address: ______________________________ Telephone: ________________

****

CLC 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) ______________________________________