



**Children's Learning Center at Mitchell College  
2025-2026 ENROLLMENT APPLICATION**

Current Date: \_\_\_\_\_ Anticipated Enrollment Date: \_\_\_\_\_

Child's Name (First, Middle, Last): \_\_\_\_\_

Nickname: \_\_\_\_\_ Gender: M / F / Nonbinary Date of Birth: \_\_\_\_\_

Child's Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ 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 - your form is not valid, and enrollment cannot be finalized if there are blank spaces**

**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

**ADDITIONAL INFORMATION:**

Children must be potty trained in order to attend. Is your child potty trained? Yes\_\_\_\_ No\_\_\_\_

Does your child have any special medical condition, allergies, or needs? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any identified special educational needs? Yes \_\_\_\_ No\_\_\_\_

If yes, please describe:\_\_\_\_\_

Has your child received Birth to Three Services? \_\_\_\_yes \_\_\_\_no

Do you have any concerns you want to share with us about your child's development? \_\_\_\_yes \_\_\_\_no

Would you like to schedule a meeting to discuss? \_\_\_\_yes \_\_\_\_no

Are there other children in the household?

Name: \_\_\_\_\_ Age: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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 Mitchell College Children's Learning Center, including the Mitchell Woods, Mitchell Beach, Mitchell Library, and Toby May Park.

Initial \_\_\_\_\_

### **SHARING CONTACT INFORMATION**

Would you like to be part of the CLC Family Directory and have your contact information shared with other families? \_\_\_\_ yes \_\_\_\_ no

How did you hear of us?

\_\_\_\_\_

### **DAYS AND TIMES MY CHILD WILL ATTEND**

The Children’s Learning Center at Mitchell College is open Monday–Friday, 7:00am–5:00pm.  
Regular drop-off is 8-9 a.m. Regular pick-up is 3-4 p.m.

**Please check-off which days & times you would like to register for:**

- Full Day: \$285 paid weekly  
Hours: Monday - Friday 8:00 am – 4:00 p.m.
  
- Half-Day: \$190 paid weekly  
Hours: Monday - Friday 8:00am–12:00pm
  
- Three-Day: \$195 paid weekly  
Hours: Monday/Wednesday/Friday 8 a.m. – 4 p.m.
  
- Two-Day: \$130 paid weekly  
Hours: Tuesday / Thursday 8 a.m. – 4 p.m.
  
- Before Care: \$75 paid weekly  
Hours: Monday – Friday 7 a.m. – 8 a.m.
  
- After Care: \$75 paid weekly  
Hours: Monday – Friday 4 p.m. – 5 p.m.

Multi-child Discount    10%  
Military Discount        10%

**CLOSURES**

Please consult the current calendar for holidays and closures. *There is no tuition reduction due to center closures.*

Should severe weather or other conditions prevent the program from opening on time or at all families will be notified through the Brightwheel App.

If the college, or New London Public Schools is closed or delayed due to weather conditions the CLC will also be closed. 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.

**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 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.

Tuition is due and payable weekly by Thursday at 4:00pm.

Initial\_\_\_\_\_

Initial\_\_\_\_\_

A late fee of \$25 will be added to your tuition for payments received after 4:00pm 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 am required 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 materials fee will be added to your initial first week deposit. This materials fee covers some of the cost of, art materials, classroom basics, 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 12:00pm in the case of half day enrollment.

Initial\_\_\_\_\_

Accounts that are past due will result in suspension or termination of contract.

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\_\_\_\_\_

I will be responsible for payment processing fees via Brightwheel:

Card Fee: 2.95%

ACH Fee: 0.6%, \$0.25 min, \$2 max

Initial\_\_\_\_\_

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

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 "2024/25 Enrollment" in Memo.**

### **Help us get to know your child!**

At the Children's Learning Center, we firmly believe that parents are vital partners in their child's educational journey. We recognize parents as their child's first teacher, and we are committed to fostering strong, collaborative relationships with parents. By working together as a team, we can create a supportive and nurturing environment where every child can thrive. We value open communication, mutual respect, and active involvement from parents, as we believe that together, we can provide the best possible educational experience for each child.

What are some of your child's favorite activities or hobbies at home?

Are there any special interests or talents your child has that you'd like us to know about?

What are some strategies that work well for your child when they're upset or need comforting?

Are there any cultural or religious practices important to your family that you would like us to be aware of?

How does your child typically react to new environments or social situations?

What are your goals or hopes for your child's preschool experience?

Is there any additional information about your child's personality, learning style, or behavior that would be helpful for us to know?

Are there any specific routines or habits from home that you would like us to maintain or incorporate into your child's day at school?

How do you prefer to communicate with teachers and stay updated on your child's progress and activities at school?  
(e.g., email, phone calls, in-person meetings)

## **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 to enroll. Health Assessment Record for children under 5 can be found on the last page of this handbook.

**Your child is also required to have a flu shot by December 31 of the current school year.**

### **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.).

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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 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 as needed.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

**PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS -- This Part Must Be Completed**

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

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Topical Medication: \_\_\_\_\_

Schedule of Administration: \_\_\_\_\_ Site of Administration: \_\_\_\_\_

Medication shall be administered from:        /        / 2024 to        /        /2025

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

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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\*\*\*\*\* Staff to complete: Parent authorization form and medication received by:

Staff Name: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

## MEDICAL ADMINISTRATION AUTHORIZATION (only if needed)

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  
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 \_\_\_\_\_

Name of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Guardian/Other Explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

Name of Childcare Personnel Receiving Written Authorization and Medication: