

Statement of Understanding

Please note that payment is due by the first of every month. No refunds will be given for missed days due to but not limited to; a sick child, personal vacations, or school vacations. Exceptions for refunds will be made at the discretion of the Board of Directors with the advisement of the School Director. Additional activities, meals, and days require advanced permission from the School Director and payment in full before the starting date of attendance. Failure to make payments on time will result in the assessment of late fees and possible dismissal from the program. Your signature confirms your understanding of the above stated conditions and agreement to fulfill your financial obligations to Parma Kids Preschool & Child Care Center around program.

Print name: _____ **Signature:** _____ **Date** ___/___/___

Photo of Child (optional)	New York State Office of Children and Family Services Day Care Enrollment		
	Child's Full Name:	Date Of Birth:	
	Child's Nickname:		
	Child's home Address:		
	Name of person Enrolling Child:	Relationship to child:	
Phone number(s) of person enrolling child: <input type="checkbox"/> ok to text		Address of person enrolling child:	
Email:			
Emergency contact /Addresses	Pick up?	Primary phone	Other phone number
Primary contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
<i>For program use only</i> Date of enrollment:		<i>For program use only</i> Date of disenrollment:	
Child's Full Name:		Date Of Birth:	
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> None <input type="checkbox"/> Allergies, please list: _____ <input type="checkbox"/> Other: _____ Please provide information here AND discuss with your child care provider:			
Child's Primary Care Physicians' Name/Group:		Phone number:	
Preferred hospital:		Phone number:	
Child's Dental Care:		Phone number:	
Child health insurance information is available by calling toll free 1-800-698-4543 or the New York State Health Marketplace website: https://nystateofhealth.ny.gov/			
Agreements			
<ul style="list-style-type: none"> • I consent to emergency medical treatment for my child<input type="checkbox"/> Yes <input type="checkbox"/> No • I consent for my child to take part in neighborhood walking trips (i.e., library, park, playground, local businesses) away from the program under proper supervision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the [program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....<input type="checkbox"/> Yes <input type="checkbox"/> No • I agree to review and update this information whenever a change occurs and at least once every year.....<input type="checkbox"/> Yes <input type="checkbox"/> No 			
Signature- Parent or person legally responsible:			Date: