



Presentation Childhood Learning Center
1725 Kennard Street
Maplewood, Minnesota 55109
phone: 651-770-3093 fax: 651-779-2307
Website: www.presentationofmary.org

Welcome to Presentation Childhood Learning Center's programs for children in preschool through school age. Please use this as a guide for completing the application and registration process. If you have questions on how to complete any forms, please call 651-770-3093. The director will be happy to assist you any way possible.

Application Procedure

- 1) Tour the center
- 2) Return application and application fee
- 3) Receive information packet and file folder

File Completion Sheet -Before you begin, please gather and consider the following: Who do you want to be your child's emergency contacts (these must be 2 people other than parent(s)/guardian(s))? Compile their names, addresses, phone numbers and email addresses. Find your health insurance information, physicians and dentist name address and phone number. Remove the Health Care Summary from the end of the packet. Drop this at your child's physician and request a copy of your child's current immunization record to be completed and faxed to PCLC right away. Allow an hour or more to complete this information.

1. Registration Form, front and back
2. Getting to Know Your Child and Family (Front)
3. Proper Care Plan (Back)
4. Parties Responsible for Tuition (Front)
5. Scheduled Attendance (Back)
6. Ages and Stages Questionnaire
7. Emergency Care (Front and Back)
8. Time and Talent Matching (CP and RRR only)
9. Health Care Summary (To be completed by Health Care Provider)
10. Immunization Record
11. Preschool tuition is paid via the FACTS Management Program. Please enroll at www.factsmgt.com

Date file completed: _____ initials: _____

Requests made on the following dates:

REGISTRATION FORM

Full Day Preschool

Monday-Friday 6:30 A.M.- 6:00 P.M.

M T W Th F _____

(Days) _____ estimated time _____

School Age circle day(s) M T W Th F _____

Monday-Friday 6:30 A.M.- 8:20 A.M. _____

Monday-Friday 3:00 P.M.- 6:00 P.M. _____

Monday-Friday 6:30 A.M.- 6:00 P.M. _____

PBVM Parishioner _____ yes _____ no _____

Reg. Fee _____ Orientation ___/___/___

Enrollment date ___/___/___ Withdraw ___/___/___

School attending if not PBVM: _____

Community Preschool

MWF A.M. _____

T Th A.M. _____

MWF P.M. _____

PBVM School Alum _____ yes _____ no _____

RRR

M-F AM _____

CHILD INFORMATION

Child's first name	Child's middle name	Sex: ___M___F	age
Child's last name	parent's/ guardian's primary language		birth date
Child's primary language			
I would like the teacher to call my child (ex: Mike instead of Michael)			

PRIMARY CONTACT AND RELEASE PERSONS- Include parents and guardian information

Primary Parent/Guardian	Relationship to child	Home Phone	Cell phone
Home Address _____ city, _____ state zip _____	home email address _____		
Employer and address _____	work email address _____	work hours _____	work phone/ext _____
Which email address do you prefer to receive PCLC communication? ___ Home ___ work ___ both ___ Needed for paperless communication			
Other Parent/Guardian	Relationship to child	Home Phone	Cell phone
Home Address _____ city, _____ state zip _____	home email address _____		
Employer and address _____	work email address _____	work hours _____	work phone/ext _____
Which email address do you prefer to receive PCLC communication? ___ Home ___ work ___ both ___ Needed for paperless communication			

EMERGENCY CONTACT AND RELEASE PERSONS- Do not include parents and guardians

Please notify PCLC the center if an emergency release person will pick up your child on a given day. For the safety of your child we will request all authorized pick up people with whom staff are not familiar to provide Government issued photo ID at time of pick up.

Name #1- Mandatory Emergency Contact	Relationship to child	Home Phone	Cell phone
Home Address _____ city, _____ state zip _____	home email address _____		
Employer and address _____	work email address _____	work hours _____	work phone/ext _____
Name #2- Mandatory Emergency Contact	Relationship to child	Home Phone	Cell phone
Home Address _____ city, _____ state zip _____	home email address _____		
Employer and address _____	work email address _____	work hours _____	work phone/ext _____
Name #3- Optional Emergency Contact	Relationship to child	Home Phone	Cell phone
Home Address _____ city, _____ state zip _____	home email address _____		
Employer and address _____	work email address _____	work hours _____	work phone/ext _____

* The persons designated in this section will be contacted by PCLC and are authorized to pick up my child if there is a medical or other emergency and I cannot be reached.

*Center Staff will release your child only to you or to those persons you have listed above. Emergencies may prevent you from picking up your child; therefore; include those individuals whom you would authorize in such events. If you want a person who is not identified above to pick up your child, you must notify center staff in advance, preferably in writing. Your child will not be released without prior authorization.

Parental Permission and Release Forms

Physician, Dentist & Health Insurance Information- All areas must be completed.

Child's Physician & Clinic Name: _____
Address _____ Phone # (_____) _____
Child's Dentist & Clinic Name: _____
Address _____ Phone # (_____) _____
Health Insurance: _____
Subscribers Name on card: _____ ID#: _____

Walking Trips

I give permission for my child to leave the center for outdoor exercise and educational purposes, with the understanding that my child will be accompanied by center staff and under proper staff supervision at all times. Permission is given to take my child on supervised walking excursions. ___ Yes ___ No Init: _____

Parent signature: _____ Date: _____

Media Release

I give permission for my child to be photographed and videotaped in the center and during program functions and on field trips. I understand that photographs/videos may be taken by center staff or by other parents/guardians. To publicize the achievements of PCLC students and the great work they perform, we would like to occasionally publish student's first names, photographs or achievement in our ministry publications or release the information to local media. Occasionally students may be interviewed or photographed by local media. Information any photographs may be posted on Presentation of Mary's website. No compensation will be due to the child or the parents for the use of the child's likeness in publications.

I give permission for my child to participate in photographs for public purposes. ___ Yes ___ No

PCLC uses social media to keep parents informed and to share information about programming.

I give permission for my child to participate in photograph in social media ___ Yes ___ No

Parent Signature: _____ Date: _____

Medical Release

As a parent/legal guardian, I give consent to Presentation Childhood Learning Center to consult the physician or dentist listed above; administer emergency first aid and/or cardiopulmonary resuscitation; call 911, and if necessary, my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation any charges not covered by insurance. I give consent for the emergency contact persons listed on the other page to act on my behalf until I am available. I agree to update this information whenever a change occurs.

If I had my choice, the hospital I prefer my child to be transported to is: _____

Parent Signature: _____ Date: _____

Interviews by licensing officials and abuse reporting:

Minnesota State Law permits licensing officials to privately interview children without advance notice. Laws also require school officials to report any reasonable suspicion of child abuse. I understand that PCLC personnel are mandated abuse reporters and unannounced interview relating to reports may occur.

Parent Signature: _____ Date: _____

In case of emergency, please list the order of people and phone number to call, For example:

1. Mom's cell (651) 555-5555, 2. Dad at work (612)555-5555 3. Mom at work (651) 555-5555 4. Aunt Susan's cell (651) 555-5555

1. _____ 2. _____

3. _____ 4. _____

Person completing this form: _____

Primary Parent/Guardian Signature _____ Date: _____

Secondary Parent/Guardian Signature _____ Date: _____

Getting to Know your Child and Family

Child's name: _____

Anticipated start date: ____/____/____

Getting to know your child.

1. Please share your immediate goals for your child with regard to socialization/academics.

2. Do you feel there are any developmental delays or concerns that we need to be aware of? _____

3. Please briefly describe a day in the life of your child. _____

4. Please describe any fears your child has. _____
5. How does your child typically react to anxiety or stressful situations? _____

6. Please describe any previous social/play group experiences. _____
7. Please list your child's special interests: _____
8. Can you share something about your child that you consider extraordinary or a strength? _____

9. Please describe anything that is particularly difficult for your child. _____

10. Is there any other information with regard to your child's development that you would like to share?

Getting to know your family.

1. Please list the names and birthdates of siblings living in your house.
Sibling Name: _____ Birthdate: ____/____/____
Sibling Name: _____ Birthdate: ____/____/____
Sibling Name: _____ Birthdate: ____/____/____
2. Are there any other family members living in your home? _____
3. Have there been or are you anticipating any changes in your child's family constellation? _____
4. Have there been any difficulties or crises in your family that may affect the emotional well-being of your child?

5. Is there anything you'd like to share about your heritage? _____
6. Are you willing and able to share, demonstrate, cook, make or teach us something about your heritage, job or a hobby? If yes, please describe. _____
7. Please describe your discipline practices in your home. _____

Please complete if your child has more than one residence.

1. This child resides with: _____
2. If your child has 2 or more residences, please describe the typical schedule. For example, 1 week at mom's house, the next week at dad's house. _____
3. Who is the legal custodian of this child? _____
4. Who has physical custody of this child? _____
5. Are there legal determinations that are not completed with regard to this child? _____
6. Would you like separate folders for each parent? _____ Yes _____ No
7. Do you want us to mail duplicate information to another part? If yes, please provide their address in the space provided:

8. Please describe the rapport between the parents of this child: _____
9. Is there any other information you'd like to share? _____

-Billing accounts can be set up separate but, *must be approved by the director.*

-Please forward all legal documents that may be important for PCLC to have on file.

Medical History

1. Special medical conditions _____
2. Chronic Illnesses _____
3. History of serious injuries or hospitalizations of which we should be aware _____
4. Diabetes Yes No
 - a. If your child has diabetes, please notify the Director. A Special Care Plan for Children with Diabetes must be completed prior to enrollment.
5. Medication that will be administered regularly at PCLC _____
6. Special dietary needs _____
7. Physical restrictions _____
8. Is your child able to fully participate in all of the activities offered by PCLC Yes No, explain: _____
9. Does your child function at the level of other children in his or her age group? Yes No, explain: _____
10. Is your child's speech easily understood by most adults? Yes No, explain: _____
11. Can your child effectively communicate his or her needs? Yes No, explain: _____
12. Does your child require any assistance at mealtime? Yes No Explain: _____
13. Does your child rest in the middle of the day? Yes No Explain: _____
14. Does your child use any special equipment, such as a breathing machine, hearing aid, etc? Yes No
 - a. Explain: _____
15. Does your child require one-to-one supervision on a regular basis for a significant period of time?
 - a. Yes No Explain: _____
16. Does your child require and/or desire any accommodations or modification to fully and equally enjoy and participate in PCLC's group care setting?
 - a. Yes No Explain: _____

Non-Prescription Medication Products Authorization Form

All over-the-counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time they are administered.

The following external products may be applies to my child in accordance with the manufacturer's instructions on the original container:

- | | | |
|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Diaper Wipes | <input type="checkbox"/> Lip Balm | <input type="checkbox"/> Sunscreen |
| <input type="checkbox"/> Skin lotions/creams | <input type="checkbox"/> Baby Oil | <input type="checkbox"/> Soap |
| <input type="checkbox"/> Chemical hand sanitizer | <input type="checkbox"/> Toothpaste | |
| <input type="checkbox"/> Other: _____ | | |

Parent/Guardian's signature: _____ Date: ____/____/____

Special Care Plan

My child requires a care plan (call the PCLC office to request this form. Please advise PCLC of your child's care plan before your child's first day of school). Severe Allergy Asthma Diabetes

Allergies- Please list allergies and reactions:

- | | |
|--|---|
| Foods: _____ | Typical Reaction: _____ |
| Drugs: _____ | Typical Reaction: _____ |
| Other: _____ | Typical Reaction: _____ |
| My child has an Epi-Pen <input type="checkbox"/> Yes <input type="checkbox"/> No | Are any of the allergies life-threatening? <input type="checkbox"/> |

My child does not tolerate the following:

- | | |
|--------------|-------------------------|
| Foods: _____ | Typical Reaction: _____ |
| Other: _____ | Typical Reaction: _____ |

Health Care Summary
Completed by physician/nurse practitioner
Presentation Childhood Learning Center FAX 651-779-2307

This form is completed by your child's primary care provider/facility

Child's Name: _____ Date of birth ____/____/____

Parent/Guardian: _____

Date of last physical exam: _____

Is the child up-to-date on their immunizations? ____yes ____no

If no, plan for bringing the child up-to-date _____

Copy of immunizations attached and signed by health care provider ____yes ____no

Allergies: _____

Does the child have any important health concerns that you are following them for? _____

Does the child have any important health concerns that are followed by another source of health care? (if so, please give name of provider and condition requiring attention. _____

Does the child have any special needs that require accommodation by the provider? _____

Does the child have any conditions that may result in an emergency? _____

Does the child have any activity restrictions? _____

Is a modified diet necessary? _____

Does the child require a different sleep position other than on their back? _____

What is the status of the child's Vision: _____

Hearing: _____

Speech: _____

Is there any other information that would be helpful in a group care setting? _____

Primary health care providers name: _____

Clinic Name: _____ Phone: (____) _____

Address: _____

Street

City

State

Zip

Phone no.

Signature of Health Care Provider: _____

Please attach immunization record



**Party or Parties Responsible for Tuition
Financial Information
Admission Agreement**

TUITION RESPONSIBILITY

1. List the party that is primarily responsible for tuition payments.

Name: _____
Signature: _____ Date: ____/____/____
Percentage of tuition this party is responsible for: _____%

2. List the party that is secondarily responsible for tuition:

Name: _____
Signature: _____ Date: ____/____/____
Percentage of tuition this party is responsible for: _____%

3. List the agency that is responsible for tuition: _____ Is there a copay? ____ yes ____ no
If yes, who is responsible for the copay? Name: _____

TUITION							
	Child	Tuition Rate	Per	Total billing cycles	Activity Fee Per year	Discount or Scholarship	Net Tuition
I understand that my weekly/monthly tuition fees are as follows:		\$	____ week ____ bi-week ____ month		\$ 50	\$	\$

FEE SCHEDULE

1. I agree to pay the full tuition fee even if my child is absent for one or more days.
2. I agree to sign my child in and out as they enter and exit the center. Failure to comply will result in a fine of \$5 per occurrence. Please note that these records are vital to PCLC.
3. Tuition will remain the same throughout the school year, even when PCLC closed for a holiday, inclement weather or any other reason.
4. All tuition is due in advance of services rendered. In-center tuition payment received after the close of business the Friday prior to service shall be assessed a late-fee. If tuition is not paid in advance as listed above, a late fee of \$5.00 will be charged.
5. Tuition will increase if your child attends Extended Care or if you need to add on additional care or activities.
6. A late tuition pick-up fee of \$1 per minute per child will be assessed when a child left beyond the program's operating hours. The late pick-up fees do not constitute an agreement to provide after -hours service, nor will the late fee be applied toward tuition. Chronic lateness at closing time may be grounds for termination of service.
7. Termination of the program by a parent must be preceded by a two-week written notice. If I do not give proper notice, I agree to pay any fees or full tuition that may be due for the final two weeks regardless of my child's attendance.
8. 1 vacation week (5 days in a row) is granted to children enrolled 5-days per week in the Full Day Preschool or School Age Care program. Vacation requests must be written and made at least one-week in advance.
9. Failure to make a timely payment will result in the termination of services offered by Presentation Childhood Learning Center.
10. Optional Special Programs such as music class are additional fees that are not paid to PCLC.
11. Preschool and Pre-kindergarten Activity Fees for the school year (Sept- May) are billed one time per year and are prorated according to the program selection. Activity fees for school age programs or summer (June- August) are billed per occurrence.
12. Curriculum Fees for a Handwriting Without Tears™ book are billed one time per year for the FDPS and RRR program.
13. All preschool tuition needs to be paid via the tuition management program selected.
14. A nonrefundable annual registration fee is due at the time of enrollment and payable each year. If my child has withdrawn from the program and subsequently re-enrolls, a new registration fee is due at that time.
15. Accounts two weeks past due may result in immediate termination of service; however, upon payment, enrollment may be reinstated with applicable paid tuition and registration fee. Outstanding accounts may be referred to a collection agency. In the event that an account is outstanding or shared payment of an outstanding account is in dispute any part of the outstanding payment not paid will be the responsibility of the parent/guardian.
16. Although PCLC may have, on one or more occasion, failed to enforce a right contained in the agreement, this does not constitute a waiver for all time.
17. I have read all additional policies and information provided in the Parent Policy Manual.

Acknowledgement of tuition policies:

Signature: _____ Printed Name: _____ Date: ____/____/____

Scheduled Attendance

SCHEDULED ATTENDANCE

Please complete for Full Day Preschool, Kindergarten Plus, School Age Programming or Summer Programming.
Tuition fees are based on the following scheduled attendance.

HOURS ENROLLED AT PCLC		IN	Out	I understand that a change in the schedule must be made in writing and may require a new Enrollment Agreement
	Mon			
	Tues			
Notes:	Wed			
	Thurs			
	Fri			

Core Program:

- Community Preschool MWF AM
- RRR AM
- Full Day Preschool
- School Age Programming

- Community Preschool T TH AM
- Community Preschool MWF PM
- Preschool Core (8 AM - 3 PM) M-F
- Summer Programming

Other Terms

1. PCLC reserves the right to alter its policies and program at any time. New policies will be in effect 30 days after publication.
2. I understand that if there is a change in any information provided I will promptly update such information.
3. I agree to notify the center by 8:30 AM when my child is absent.
4. I will notify PCLC if my school-age child does not need to attend PCLC in the afternoon by 2:30 PM.
5. I agree to sign my child in and out as they enter and exit the center.

I certify that I have read, understand and accept all of the terms and condition described in this agreement. This agreement is effective on: ____/____/____.

Primary parent/guardian signature

date



EMERGENCY CARD- Kept separate from other info

Child's Name: _____ Birth Date: _____

Home address: _____
Street City State zip

Parent/Guardian #1: _____
Name address day phone (hm, cell, wk) other phone (hm, cell, wk)

Parent/Guardian #2: _____
Name address day phone (hm, cell, wk) other phone (hm, cell, wk)

Emergency Contacts (To whom child may be released if parent/guardian is unavailable)

Name #1 _____ Relationship _____

Address _____ Daytime phone (hm, cell, wk) _____ other phone (hm, cell, wk) _____
 Name #2 _____ Relationship _____

Address _____ Daytime phone (hm, cell, wk) _____ other phone (hm, cell, wk) _____

Primary Care Physician (PCP) name		Practice/ Clinic Name	
PCP address			phone
Preferred hospital/clinic for emergency care			
Dentist name		Practice/Clinic Name	
Address			Phone
Health Insurance Provider and Policy Number		Secondary Health Insurance Provider and policy number	

-----fold here-----

EMERGENCY CARD- Kept separate from other info

Child's Health Insurance: _____

Subscribers Name (on insurance card): _____ ID #: _____

Specific instruction of special conditions, disabilities: _____

Allergies: _____ Epi Pen ____yes ____no

In case of an emergency, please list the order of people and the phone numbers to call.

1. _____ 2. _____
 3. _____ 4. _____

As a parent/legal guardian, I give consent to Presentation Childhood Learning Center to administer to my child emergency first aid by the program staff. I understand that if necessary, 911 will be called and, my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance. I give consent for the emergency contact persons listed above to act on my behalf until I am available. I agree to update this information whenever a change occurs.

Parent/Guardian's signature #1: _____ Date: _____

Parent/Guardian's signature #2: _____ Date: _____

