



Small Spuds childcare & preschool

6219 Butte View Dr, Boise, ID 83704
559-5127

smallspuds@gmail.com www.small-spuds.com

Child Care Contract

The following agreement is made between:

1. _____
Mother/Legal Guardian Home Phone Work Phone

Home Address

Employers name and Address

and

2. _____
Father/Legal Guardian Home Phone Work Phone

Home Address

Employers name and Address

and

3. Tami Olsen 208-559-5127
Small Spuds Child Care and Preschool, 6219 Butte View Dr, Boise, ID 83704

For the care of:

4. _____
Child's Name/Date of Birth Child's Name/Date of Birth

Child's Name/Date of Birth Child's Name/Date of Birth

Payment Policies and Rates

Payment in the amount of \$525 per month is payable to: **SMALL SPUDS CHILD CARE** for child care provided per childcare schedule below. An enrollment fee of \$50.00 is required to be paid when this contract is returned and will be applied to the first month's payment or forfeited if the child does not come for care as agreed.

DATE CARE TO BEGIN: _____

Care shall be provided normally from ____ a.m. to ____ p.m. on these days :(circle all that apply) If additional days are needed outside the normal schedule, there will be an additional daily rate charged for those days. The daily rate is prorated based on the amount you pay monthly.

Monday Tuesday Wednesday Thursday Friday

Payment is due before care is provided with no exceptions.

Please choose the payment arrangement that works for you

- Pay whole amount due on the 1st of the month.
- Pay amount due in 2 equal installments, one on the 1st and the other on the 15th of the month.
- Pay the amount due in 4 equal installments due on the first 4 Mondays of the month.

LATE FEES AND NSF FEES:

\$10 late fee for each day that payment is **overdue**. Care will not be available, until payment is made in full.

\$25 returned check fee. Any returned checks, will result in future payments of cash only. The amount of the returned check plus the fee is immediately due to the provider.

\$5 for every 15 minutes, if care is provided after 6:00 pm or over 10 hours per day.

TRIAL BASIS:

All Parties agree and acknowledge that the first 2 weeks of care is provided on a temporary basis.

TERMINATION:

All parties agree and acknowledge that either party will be required to give 2 weeks notice, prior to termination of care and/or services. Payment by the parent/guardian is due for the notice period, whether or not the child is brought to the provider for care. The provider may terminate the contract without giving any notice if the parent/guardian does not make payments when due. Failure by the provider to enforce one or more terms of the contract does not waive the right of the provider to enforce any other terms of the contract.

RATE INCREASES:

Provider reserves the right to increase childcare rates at the end of each year with 30 days written notice.

SIGNATURES:

By signing this contract parent(s)/guardian(s) agree to abide by the written policies in the Small Spuds Parent Handbook. The Provider may amend the Parent Handbook at any time by giving the parent(s)/guardian(s) a copy of the new or changed Parent Handbook at least 2 weeks before it goes into effect. The Parent/Guardian is also stating they have received a copy of the Parent Handbook and Orientation before their child started with Small Spuds.

Provider's Signature _____ Date _____

Mother/Legal Guardian's Signature _____ Date _____

Father/ Legal Guardians Signature _____ Date _____

Enrollment Form

BASIC INFORMATION

Name of Child _____ Birthdate _____

Mothers Name _____ Home Phone _____

Home Address _____ Email _____

Work Address _____ Employer _____

Work Phone _____ Cell Phone _____

Father's Name _____ Home Phone _____

Home Address _____ Email _____

Work Address _____ Employer _____

Work Phone _____ Cell Phone _____

Child Lives With: Mother _____ Father _____ Other _____

Other Children Living with Child:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

HEALTH HISTORY

Check Illnesses Child has had:

Asthma Pneumonia

Chicken Pox Rheumatism

Diabetes Scarlet Fever

Epilepsy Strep Throat

Measles Whooping Cough

Mumps Other _____

Allergies (food, drug, bee sting, etc.) list type, symptoms and treatment required _____

Does your child have any special needs/chronic illnesses that require accommodation by the provider?

If so please list:

DEVELOPMENTAL BACKGROUND

Name of previous child care program attended _____

Does child have any special problems/fears _____

Child's Favorite Activities _____

Child's Nap Pattern _____

Child's Favorite toy or blanket _____

Potty Trained? Yes ____ No ____

Child's Eating Habits _____

Please list their top 5 Favorite Foods

What makes your child frustrated or upset? _____

Family rules that the provider should know about? _____

What methods of discipline do you find work best for your child? _____

Please list a few goals you have for your child while they are in our

care _____

PICK UP AUTHORIZATION

Please list the names of other people approved to pick up your child from Small Spuds. When they arrive to pick up your child they will be asked for photo ID. Please list additional names on the back of this paper.

NAME _____ Name _____ Name _____

MEDICAL EMERGENCY CONSENT

Name of child's physician or health clinic _____

Phone Number _____

Medical Insurance Co. _____ Policy # _____

Hospital Preference _____

Dentist _____ Phone _____

When there is a medical emergency, or when a child needs immediate medical treatment, the provider will take all reasonable steps to see that the children her care receive adequate medical care. When appropriate, the provider will call 911 and the parents. If the parents cannot be reached, the provider will call the persons listed below who are authorized by the parent to give permission for the medical treatment of the child. These persons authorized to do so are:

Name _____ Phone _____

Name _____ Phone _____

If the parents and the authorized persons cannot be reached, the provider will call the child's doctor, identified above. If the child must be taken to the hospital, the provider will take the child to the hospital identified above. If under the circumstances, it is more reasonable to bring the child to another hospital, the provider will do so. In the situation where the parents and the persons authorized to give permission for medical treatment are not able to be reached, the parent authorizes the child's doctor to provide the appropriate medical treatment for the child.

Provider's Signature _____ Date _____

Mother/Legal Guardian's Signature _____ Date _____

Father/ Legal Guardians Signature _____ Date _____