



**Payment is due: \_\_\_\_\_ with no exceptions.**

**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.

**SICK DAYS:**

Childcare will not be available for child/ren exhibiting more than minor cold symptoms, which impair their functioning. Parents agree to pick up child/ren within one hour of notification, should their children become ill.

**HOLIDAYS AND CLOSURES:**

Small Spuds Child Care is closed on the following days: New Years Day, Memorial Day, 4<sup>th</sup> of July (if the holiday lands on a weekend we will take the recognized day off), Labor Day, Thanksgiving and the Day after, Christmas Break – see Holiday Sheet For Exact Dates

**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.

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 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, foods \_\_\_\_\_

Child's Nap Pattern \_\_\_\_\_

Child's Favorite toy or blanket \_\_\_\_\_

Potty Trained? Yes \_\_\_\_ No \_\_\_\_

Child's Eating Habits \_\_\_\_\_

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? \_\_\_\_\_

**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 \_\_\_\_\_

Co-Signers Signature \_\_\_\_\_ Date \_\_\_\_\_

If the parent or legal guardian is under age 18, a co-signer must sign this agreement and act as a guarantor to the contract and agree to be bound by all financial terms.