Kidde University Capitol Hill
728 F St. NE
Washington, D.C. 20002
(202) 544 - 4544

Kiddie University H Street
806 H St. NE
Washington D.C. 20002
(202) 768-9814

ENROLLMENT CHECKLIST

Start Date ______/_______/_______ **Assigned Classroom**_______________

Child's Name:____________________________**D.O.B:**__________**Age**_____________

Parent's Name:____

Address:____

E-mail Address____

Home Phone______________________ **Work Phone:**___________________________

Below to be completed by Kiddie University staff only

Enrollment Fees:

Registration/Security Deposit Fee $______
Weekly Tuition Amount $______________
Method of Payment: __________
Yearly Activity $_______

OSSE State Required Forms:

Registration Record: ___
Immunization Record: ___
DC Health Certificate: ___
Travel & Activity Authorization: ____
Oral Health Certificate: _____
Emergency Medical: ____

Kiddie University Forms:

Child Profile: ____
Tuition Agreement: ____
Parent Media Consent____
Handbook Acknowledgement: ____

Infant & Toddler Additional Enrollment Forms:

Infant/Toddler Schedule:____
Consent(Sleeping Cot):____
Potty Training Consent:____

Take Home / Online Forms:

Thank You/ Welcome Letter:___
Parent Handbook:___
Daily Needs List (Infants /Toddlers):___
Daily Needs List Preschool:___

HOW DID YOU HEAR ABOUT US: ____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: ______________________________ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: ____________ Home #: ____________ Language Spoken At Home ____________

Home Address: ______________________________
Number Street Apt. # State ZIP

Parent: ______________________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________________
Number Street Apt. # State ZIP

Business Address: ______________________________
Number Street Apt. # State ZIP

Parent: ______________________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________________
Number Street Apt. # State ZIP

Business Address: ______________________________
Number Street Apt. # State ZIP

Relative or Guardian: ______________________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________________
Number Street Apt. # State ZIP

Business Address: ______________________________
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

______________________________ Relationship to child: ____________
Last First M.I.

Address: ______________________________
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

____
Last First M.I.

____
Last First M.I.

____
Last First M.I.

Signature: ____________ **Relationship to child:** ____________ **Date:** ____________

TO BE COMPLETED BY THE FACILITY

Date of Admission: ____________

Date of Withdrawal: ____________ **Reason:** ____________

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information **Parent/Guardian:** ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐ M ☐ F	Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____
Parent or Guardian Name:	Telephone: ☐ Home ☐ Cell ☐ Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐ Home ☐ Cell ☐ Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____		Primary Care Provider (PCP):	

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: ____________________________/________________________/________________ Date of Birth:_____/_____/________
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month____________ Year___________ Verified by:____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____________________________________ _______________________________ _________
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____________________________________ _______________________________ _________
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____________________________________ _______________________________ _________
Signature of Medical Provider Print Name or Stamp Date

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child ______________________________________, born on ______________________, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: ____

Address: ____

or:

Physician: ____________________________ M.D. Telephone No: ________________
(Area Code)

Address: ____

I give permission to ____, located at
Name of Facility or Caretaker

____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: ________________________________

Name of Policy Holder: ________________ Relationship to Child: ________________

Policy Number: ________________ Coverage: ________________

Medicaid Number: ________________ State: ☐ DC ☐ MD ☐ VA

Child's Known Allergies or Physical Conditions: ________________________

____

Signature: ________________________ Relationship to Child: ________________

Address: ____

Telephone No: ________________ ________________ ________________
Home **Business** **Pager/Cell Phone**

Date: ________________________ Date Updated: ________________________
Month/Day/Year Month/Day/Year

NOTE: Place on file in child's folder/record

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002

PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

☐ Special 1-time permission for this activity only ☐ Blanket permission for all given activities

I, ____ parent/guardian of
Name of Parent/Guardian

____ give my permission to
Name of Child

____ for my child to participate in the following activities:

Trips in the van/automobile (facility or parent -owned)

____
Explain planned activity — where and when

Field trips away from the facility

____
Explain planned activity — where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,
☐ I will allow my child to play outside the fenced area; or _______
☐ I will not allow my child to play outside the fenced area.

This authorization is valid from ______/______/______ to ______/______/______

____ ________________________
Parent/Guardian Signature Date Signed

NOTE: Place on file in child's folder/record

CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name		*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*School or Child Care facility:*	
Parent/Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*		*Home Address:*			*Ward*
Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*		*City/State (if other than D.C.)*		*Zip code:*	
Race/Ethnicity: ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*__________________						
Primary Care Provider (Medical):		*Dentist/Dental Provider:*	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other* ___________________________________			

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam ____________________________

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _______	17 ______	A ______	K ______
2 _______	18 ______	B ______	L ______
3 _______	19 ______	C ______	M ______
4 _______	20 ______	D ______	N ______
5 _______	21 ______	E ______	O ______
6 _______	22 ______	F ______	P ______
7 _______	23 ______	G ______	Q ______
8 _______	24 ______	H ______	R ______
9 _______	25 ______	I ______	S ______
10 ______	26 ______	J ______	T ______
11 ______	27 ______		
12 ______	28 ______		
13 ______	29 ______		
14 ______	30 ______		
15 ______	31 ______		
16 ______	32 ______		

Key (Check Appropriate)

S - Sealants
X - Missing teeth
● Restoration
|| Non-restorable/ Extraction
1D-One surface decay
UE- Unerupted Tooth
2D-Two surface decay
3D-Three surface decay
4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	**Y** **N**	
2. Plaque and/or Calculus	**Y** **N**	
3. Abnormal Gingival Attachments	**Y** **N**	
4. Malocclusion	**Y** **N**	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to ___________________		
DDS/DMD Signature	*Print Name*	*Date*
Address		
Phone	Fax	

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information. *I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health*	
PRINT NAME of parent or guardian	
SIGNATURE of parent or guardian	*Date*

<u>Instructions For Completion of Oral Health Assessment Form</u>: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that all children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

<u>General Instructions:</u> Please use black ball point pen when completing this form.

Part 1: Child's Personal Information
Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: **Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.**
Please use key to document all findings for each tooth. An '**X**' signifies a missing tooth (teeth) with no replacement; | | non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.

- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. **Final Evaluation/Required Dental Provider Signature**; Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete refer patient for follow up care. Dentist must s**ign, date, and provide required information.**

Part 5 Required Signatures. <u>This Form Will Not Be Complete Without Parent or Guardian Signature & Date</u>
The parent or guardian must print, sign, and date this part. By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.

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CHILD PROFILE

Date:_____________________

Child's Name____
First Middle Last

Parent's Marital Status: ( ) Married ( ) Single ( ) Divorced

IN CASE OF EMERGENCY CONTACT
Name:___________________________________Phone:________________________________
Address:____

Siblings
Name:____ Age: ___________
Name:____ Age: ___________
Name:____ Age: ___________

Other Members in Household:____

Who will deliver your child to school?_______________________________________

HEALTH: Does your child have any allergies?________________________________

If yes, do you consent to us posting notification of your child's allergy visibly in each classroom for every teacher to be informed at all times? Yes (recommended) No

Is your child covered by hospitalization and/or accidental insurance? Yes No

Name of Carrier______________________________Policy No.________________________

What was the date of your child's last physical exam?______________________________

What are your child's food likes?____________________dislikes?_____________________

Does your child have any physical or emotional disabilities? Yes No
Please explain

Does your child have any disease or other health conditions? Yes No
Please explain

Is your child on any medications?____

BEHAVIOR PATTERNS

What is your child's nap routine?____

What are your child's favorite activities? ____

Does your child have any particular fears we should know about? ___________________

How do you reward or discipline your child? ______________________________________

What would you like the teachers to know about your child's behavior or personality?
____

OTHER INFORMATION

Name of Your Child's Previous School ____

Any Additional Comments____

____

____

____

____

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TUITION FINANCIAL AGREEMENT

This Tuition Financial Agreement ("Agreement") is made on _______________, 20___by and between Kiddie University ____________________ ("Kiddie University" or "Center") and ("Responsible Party" or "Parent") ____.

1. **TERM OF AGREEMENT**. This Agreement shall be effective on the date signed by a Kiddie University representative and shall continue in effect until termination pursuant and subject to the terms and conditions herein. Subject to the terms and conditions herein, upon the happening of any of the following events, this Agreement is terminated:
   a. If Kiddie University elects, upon default of any payments to Kiddie University;
   b. Upon Kiddie University's written notice to the Responsible Party, with or without cause, at any time; or
   c. Upon the Responsible Party's option and after at least one (1) month written notice along with final payment, with or without cause; or
   d. Upon mutual written agreement between the parties to terminate the Agreement. Under any circumstances, any obligations of the Responsible Party if in "Default", shall survive the termination of this Agreement.

2. **METHODS OF PAYMENT**. I agree to pay my child's tuition on every Monday, in advance of services provided, or any frequency specified by Kiddie University upon 30 days prior notice. I understand that the tuition payment will be made by automatic debit from my account by a third party vendor, which at this time is called SMARTCAREOS, LLC ("Smart Care"). I agree to complete the required forms with my account information, which will allow Smart Care to perform the automatic debit from my account. I understand that any agreement between me and Smart Care is independent of Kiddie University and any disputes regarding the debits will be resolved with me and Smart Care. I understand, however, as a courtesy, Kiddie University will assist in resolving disputes at my request. I understand that if my automatic deduction fails on that Monday, I will incur a $50 charge, in addition to applicable late charges, which will be due immediately along with the tuition charges, for my child to return to the Center. These payments will be due in the form of certified check or money order and delivered directly to Kiddie University upon return or your child.

3. **WEEKLY TUITION**. I agree to pay Kiddie University, **in advance,** the weekly tuition in the amount of $ ___________ or the current tuition applicable to my child's age, whichever is greater, during the entire term of this Agreement on a weekly schedule. I understand that there is no deduction for absences, holidays, vacations, illness, closures due to inclement weather or staff development time, which is currently one (1) full day session at the end of the summer annually and (1) full day for OSSE training session given annually, date to be determined by OSSE. Kiddie University will inform Parents as soon as the OSSE training date is provided to the Center. Tuition is based on a weekly rate for full- time care and will not be prorated unless through written consent of the Center Director.

4. **LATE CHARGES.** I agree that if the Tuition including any other accrued fees and charges, is not paid to Kiddie University on or before the close of business on Wednesday for the

week for which the tuition payment is due, I shall pay, in addition to the Weekly Tuition and other accrued fees and charges a Late Payment fee of $10.00 per day including the day of payment but excluding holidays and weekends. I understand that my child can be automatically withdrawn from the Center if payments are not made on time.

5. **RETURNED CHECK CHARGE.** I understand and agree that if any check or automatic debit to Kiddie University is returned unpaid by the bank for whatever reason, the Undersigned shall pay a Returned Payment Charge of $50.00.

6. **ACTIVITY/MATERIAL FEES.** I agree to pay a Summer Activity/Material Fee of $__________ for each child in June or each year. I understand that this fee is included in my initial registration fee for the first year and is due each year thereafter.

7. **REGISTRATION FEE.** I agree to pay a Registration Fee in the amount of $__________for each child. This is required upon enrollment. I understand that I have up to three (3) days to cancel and receive a full refund of my registration fee. After the three day period, I agree to forfeit my registration fee in its entirety.

8. **ARRIVAL/DISMISSAL AND LATE PICK-UP FEE.** I understand and agree that:
   - Children are not permitted at Kiddie University before 7:00 AM.
   - An adult must accompany all children into the Kiddie University facility.
   - Kiddie University shall release children only to persons listed on the Registration Record.
   - I agree to pay Kiddie University, after 6:00 PM, a Late Pick-up Fee of $15 for each child plus **$1.00 for each minute thereafter 6:05 PM** for each child that is picked-up after the 6:00 PM closing.

9. **WITHDRAWAL.** I understand that the enrollment of my child is for a full year. This is a full year round program. However, I understand that I may withdraw my child at any time during the year by giving the Center a **one month notice**. I understand that I must complete a withdrawal form and discuss my financial status with the Director to make sure I have met all of my financial obligations to Kiddie University.

10. **ENTIRE AGREEMENT**. This Agreement constitutes the entire agreement between the parties relating to the subject matter hereof, and supersedes all previous agreements of the same title between the parties hereto, both oral and written, and this Agreement may not be modified except by agreement in writing.

11. **SEVERABILITY.** The invalidity or unenforceability of any provision of this Agreement shall not affect the remaining provisions of this Agreement that are valid under the laws of this State.

12. **GUARANTEED START AGREEMENT.** The registration fee and activity/material fees are due as a nonrefundable deposit in order to be given a guaranteed space or start date. I understand that Kiddie University will hold a space for my child(ren) and that I will be responsible for full fees effective that date, whether the child(ren) is in attendance. In the event the child(ren) fails to start on the agreed upon guaranteed start date, fees will automatically be added weekly. Failure to pay these fees will constitute a forfeiture of the deposit (as explained above) as well as the child's spot in the Center.

I have read and fully understand and agree to all parts of the Tuition/Financial Agreement. I will comply with all the terms and conditions stated. Any funds not paid according to the terms of this agreement will be subject to a filing of suit in Small Claims Court or advanced collections procedures. If these steps must be taken, I agree to pay all costs of collection, including legal/attorney fees and court costs.

Children Name:

____

____

____

Parent/Guardian:

Signature: _______________________________________
SSN: ____

Signature: _______________________________________ Date: ______________
SSN: ____

Kiddie University:

Representative: ___________________________________
Print Name and Title

Signature: _______________________________________ Date: ______________

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MEDIA / PHOTO RELEASE FORM

As the parent of a child/children at Kiddie University, I agree to the following:

• I understand that my child(ren) whose name(s) are listed below may be photographed during normal daycare hours, field trips, or activities.

• I understand that these photographs may be used in my child's folder, school newsletters, the Kiddie University website, and/or Facebook page.

• I give permission for my child(ren)'s photographs to be posted to the center wall, website, Facebook page, or newsletters. (When names are added, only first names will be used.)

The following are the names of my children attending Kiddie University:

_____________________________ _____________________________

_____________________________ _____________________________

Name (Please Print) ____

Signature ____

Date________________________

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KIDDIE UNIVERSITY CAPITOL HILL CDC
PARENT HANDBOOK ACKNOWLEDGMENT FORM

The Kiddie University Parent Handbook was created to promote an understanding of the policies and procedures at all Kiddie University locations.

I have received a copy of the Student/Parent Handbook. I have read the handbook and understand all the rules and regulations, guidelines and expectations. I agree to comply with all of these rules and regulations, guidelines and expectations of the school.

I understand that this handbook may be amended during the year without notice. This handbook in the latest version is applicable to all students upon the implementation of any change. The administration will notify all parents and students in writing, where possible, of any changes to the handbook as soon as is practicable.

______________________________ __________________
Parent Signature Date

______________________________ __________________
Parent Signature Date

____
Child’s Name

____
Child’s Name

______________________________ __________________
Signature Received by (Center Staff) Date Received

Sign and Return to office