

Angels Alley Parent Handbook Acknowledgement

Child's Name

Start Date

Address _____

Phone # _____

The Angels Alley Parent Handbook was created to promote an understanding of the policies and procedures at Angels Alley.

The information in the Parent Handbook applies to all enrolled children at Angels Alley. It is important that parents and children are familiar with these expectations.

Please be sure to read the handbook in its entirety, complete this form, and return it with the other required forms to the center. Your child will not be able to start at Angels Alley without having completed and returned this form. Your signature means that you have received, read, and understand the policies and procedures of Angels Alley.

I have read and understand the policies and procedures in the Angels Alley Parent Handbook. I agree to abide by them as will my child(ren).

Parent Signature _____

Date _____

Angels Alley 2008-2009 Fee Schedule

Registration Fee: \$50.00 first child
\$25.00 each additional child

Weekly Flat Rates for children scheduled 29-50 hours:

Ages 6 weeks – 18 months: \$154.50
Ages 18 months-30 months: \$136.00
Children over 30 months: \$117.00

Hourly Rates for children scheduled less than 29 hours:

Ages 6 weeks -18 months: \$5.15 per hour
Ages 18 months-30 months: \$4.65 per hour
Children over 30 months: \$4.15 per hour

Drop In Care for School-Age Children \$6.00 per hour

Related Fees:

There is a late pick up charge of \$1.00 per minute, per child, for children picked up after our closing time of 7:30 pm.
An excess hours charge will be applied for children staying past scheduled time.
An excess hours charge of \$5.00 per hour will be applied for children in our care more than the maximum weekly 46 hours.
All parent pay tuition payments are due on the first scheduled day of the week or in advance. A \$10.00 late payment fee will be assessed on accounts not paid on time.
There is a late scheduling fee of \$5.00 for schedules submitted after 12 pm on Wednesday.
Returned checks will be subject to a bank fee of \$25.00. Following two returned checks, tuition must be paid by cash or money order.

Policies:

There is a 15% tuition discount for siblings. Discount is off the older child's tuition.
Associates of LHS will pay tuition through payroll deduction.
No credits will be given for missed days unless a notice of cancellation is received from the associate's department supervisor.
There is a minimum scheduling charge of 6 hours per week, per child, unless parent provides written notification of absence due to vacation.
Failure to schedule for more than 2 weeks, without notification, will result in forfeiture of child's enrollment at Angels Alley.
Childcare services will be terminated and accounts will be sent to collections on any account two or more weeks past due.

I have read and understand all of the policies and fees described in this fee schedule.

Parent's Signature: _____ Date _____

PARENT PAYMENT AGREEMENT

LHS Associates: Please read and sign both the child care payment agreement and the payroll deduction authorization form.

Non-associates: Please read and sign the child care payment agreement, only.

Child Care Payment Agreement

1. I agree to pay the cost of child care services, according to the payment policy.
2. I understand that I am legally liable for payment for child care services.
3. If I should terminate enrollment, I will be responsible for paying all outstanding child care debts.

Parent's Signature: _____

Guarantor's Signature: _____

Date: _____

Payroll Deduction Authorization Form

I, _____, authorize Our Lady of Lourdes Medical Center to deduct, on a bi-weekly basis, payment for scheduled child care services at Angels Alley, in accordance with current schedules of weekly and hourly tuition rates.

Name _____ (please print)

Employee Number _____ (soc. Sec. #)

Date: _____

Signature: _____

Enrollment Information

Child's Name: _____ Age _____ DOB _____

Address: _____ City _____ Zip _____

Parent's/Guardian's Information: **(All phone numbers required)**

Mother's Name: _____ Home Phone: _____

Mother's Work: _____ Work Phone: _____

Mother's Cell: _____ Lourdes Associate: _____ Y _____ N

Father's Name: _____ Home Phone: _____

Father's Work: _____ Work Phone: _____

Father's Cell: _____ Lourdes Associate: _____ Y _____ N

AUTHORIZED OTHERS PERMITTED TO PICK UP CHILD (photo ID required):

NAME	RELATIONSHIP	PHONE
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

AUTHORIZED OTHERS PERMITTED TO SIGN FOR EMERGENCY TREATMENT:

NAME	RELATIONSHIP	PHONE
1. _____		
2. _____		

Child's Physician: _____ Phone: _____

Physician's Address: _____

Pre-Enrollment Information

Child's Name _____ DOB _____

Parent's Name _____ Relationship _____

1. Briefly describe your child's eating habits and food preferences.
2. Briefly describe your child's present sleeping habits. Naps? How does he/she act when tired?
3. Does your child have any particular routine or special words about toileting?
4. Besides you, are there any other adults or children (relatives, friends, neighbors, other teachers, etc.) that have an important influence on your child's daily life? Describe.
5. Please list all persons (children and adults) who live in your home and their relationship to your child.
6. Do you have any pets? What types and what are their names?

7. Have you and your child had any extended separations from each other? If so, how long and for what reason? Who cared for him/her during that time?

8. How does your child act now when you have to leave him/her? What do you find is best to say or do at these times?

9. Has your child attended any other babysitter, childcare center or nursery school program? If so, where and for how long?

10. How did your child enjoy that experience? Were there things that he/she disliked about that experience?

11. Does your child know about his/her potential enrollment at Angels Alley? If so, what has your child asked or said about it?

12. How does your child respond to people that he/she does not know well at this time?

13. How does your child most easily adjust to new situations and experiences?

14. How long do you think your child will stay with an activity such as a book or blocks at this time?

15. How does your child show he/she is happy, frightened, upset, or needs comforting? What is the best way to handle this?

16. What do you hope your child will gain from his/her experience at Angels Alley?

17. Please give us any additional information about your child that we should know.

Infant Room Information Sheet

(Required for enrollment in the Infant Program)

Child's Name _____ DOB _____

What is your baby currently drinking?

How many ounces does your baby drink per feeding? How often?

What does your child eat for breakfast, lunch, and dinner?

Does your baby suck his/her thumb or take a pacifier?

What calms your baby?

Infant Sleeping Position Preference

It is important for the child care providers at Angels Alley to obtain information from our parents as to the position they wish their infants to sleep. Our recommendation, in accordance with The American Academy of Pediatrics, is that infants be put to sleep on their backs. However, you have the option of choosing a different position option for your child below. More information about the recommended sleep position for infants can be found on The American Academy of Pediatrics at www.aap.org.

My sleeping preference for my child is indicated below:

_____ supine (on belly)

_____ side (right or left)

_____ prone (on back)

Child's Name _____

Parent's Name (print) _____

Parent's Signature _____

Date _____

Injury/Emergency Treatment

The staff of Angels Alley Child Care Center will take responsible measures to supervise the children's daily activities. In the course of a day, a child may be injured. The center will notify the parents immediately of any serious injury. An injury form will be completed for any child with a non-serious injury. In cases of extreme emergencies, children will taken to Our Lady of Lourdes Medical Center and parents/emergency contacts will be called.

I authorize my child, _____, to be taken to Our Lady of Lourdes Medical Center for emergency medical care. I WILL ASSUME FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY OUR LADY OF LOURDES MEDICAL CENTER ON BEHALF OF MY CHILD(REN).

Parent's Signature: _____

Date: _____

Insurance Name and number as it appears on card:

Information to Parents Acknowledgment

Name of Child: _____

Name of Parents: _____

I have read and received a copy of the Information to Parents document prepared by the Bureau of Licensing in the Division of Youth and Family Services.

Signature: _____ Date: _____