



# Enrollment Paperwork

1612 Truax Blvd.  
Eau Claire, WI 54703  
Office: 715-831-9944  
Fax: 715-831-9962

*"A Quality Investment in our Children's Educational Future"*

**Bright Beginnings Early Learning Center**  
**A Division of Brighter Educational Programs, Inc.**

**Contract Agreement Form**

**As the Parent/Guardian of \_\_\_\_\_, I/we agree to:**

1. Have read and will abide by all the guidelines as stated in the Parent Handbook.
2. Comply with the Bright Beginnings Early Learning Centers policies and procedures regarding payment and any further amendments.
3. Pay tuition fees on time. Tuition is billed on a **2-week prepayment basis**. Payments will be automatically deducted from the account specified on the tuition express authorization form on Friday's of the billing week. Accounts with non-sufficient funds will be charged a **\$35 NSF charge, the tuition express return fee, and a \$25 late fee per week** until the funds are available or until the account is paid in full.
4. Abide by the centers health policies prohibiting my child from attending the program when sick or if the proper immunization records are not on file. If required physical/immunization forms are not on file, I understand that my family will be suspended and charged the 2-day minimum fee until all proper records are present for a maximum of a 2-week time period or until my withdrawal notice is given to the center. If after the 2-week time period has passed, and the forms have not yet been turned into a member of management, we will consider your family self-terminated from our program.
5. Pay for nay non-attendance days beyond the personal time allocated.
6. **Pay \$15.00 for every 5 minutes** remaining in the center after the closing hours of 6:30pm.
7. **Pay \$10.00 for every 15 minutes** a child remains in the program beyond their contracted pick up time if sufficient notification is not given to the management staff.
8. Children in attendance **over 11 hours** will be charged a flat rate of an **extra \$10.00 per day**.
9. Provide the center with a **2-week written notice** if terminating the service. **Personal days may not be used during the 2-week notice.**
10. Turn in scheduling calendars by the **15<sup>th</sup> of every month prior to the month needing care**. **A \$50.00 non-refundable late fee** will be applied if the calendar is not turned in on time. If the calendar is not turned in with in 2-weeks of the due date, enrollment will be considered terminated by the parents/guardian and the child/children's spot will be filled.
11. A **2-day minimum** is required for all families enrolled at Bright Beginnings. (This does not include school-age children that attend school days out for snow days)
12. Abide by the calendar/contracted time as indicated. If my child is going to be absent or late **I understand that I must call in by 9:00am or I may be unable to attend for that day**. I understand that I am financially responsible for days/hours of care specified and may not switch days or use a personal day if I neglect to call in absent or late. (Personal days may be used if the absence is called in no later than 9:00am)
13. Parents are responsible for all medical costs incurred with respect to their child/children while attending the program. (Bright Beginnings does not carry a general health and accident insurance policy covering children injured by normal play)
14. I have read the parent handbook and understand the specifications listed above.

**Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_**

**Brighter Beginnings Early Learning Center**

**Sponsor:**

**CoSponsor:**

**Home Phone:**

**Home Phone:**

**Work Phone:**

**Work Phone:**

<b>Child's Name:</b>	<b>DOB:</b>
----------------------	-------------

**Family Doctor**

**Family Dentist**

**Family Hospital**

**Emergency Contact 1**

**Emergency Contact 2**

Name:

Name:

Phone Number:

Phone Number:

**Authorized Pickup 1**

**Authorized Pickup 2**

**\*\*Each authorized person must have their own, 4 digit code\*\***

**Sponsor Code:**

**CoSponsor Code:**

**Other Authorized Pickup names and codes:**

**Email:**

# General Permission Slip

**Child's Name:** \_\_\_\_\_

By signing this form, permission is hereby granted for my child to:

- Take field trips during the school hours in the company of his/her teacher. Specific information will be provided before each field trip.
- Go on local walks (Ex: Dove Healthcare, May's Floral, Roosevelt, and across the street sidewalk walks.) I understand that I will be notified of any walking trips that my child has taken on the dry erase board or on their daily sheet.
- Go on walks outside of the fence, but on the premises of Bright Beginnings.
- Be photographed/videotaped. During their time at Bright Beginnings students may be photographed and/or videotaped during classroom activities. The pictures may be used in newsletters, yearbooks, graduation videos, slide shows or local newspapers/news casts.
- Use instant hand sanitizer when no soap or water is available for use (Ex: Field Trips)

I have read and understand that I give permission for my child to participate in the above activities.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name Printed:** \_\_\_\_\_

If you would like your family to participate in the Bright Beginnings Family Directory, which will remain in the parent resource area, please fill out the information below.

**Parent(s)/Guardian Name (Last, First):** \_\_\_\_\_

**Child/Children's Names:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Bright Beginnings Early Learning Center  
Child Emergency Registry Form**

**Today's Date:** \_\_\_\_\_

**I, the (Parent / Guardian) of \_\_\_\_\_, hereby**

(Please print child's full name)

empower and authorize emergency care and treatment for the above named child. I do hereby indemnify and hold harmless the Child Care Staff, physicians, hospital, and all others who act in reliance upon this authorization.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Home Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Emergency Contact Name and Relationship to Child)

\_\_\_\_\_  
(Emergency Contact Phone Number)

\_\_\_\_\_  
(Child's Date of Birth)

\_\_\_\_\_  
(Name and Phone Number of Child's Physician)

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_

My child has a pertinent medical history of:

Diabetes                       seizures/epilepsy                       congenital heart disease

Malignant hyperthermia                       Other \_\_\_\_\_

No significant medical history

Insurance Plan & Policy Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_