Trinity Day Care
215 N. 1st Street
Rockford, IL 61107
815-986-KIDS(5437)
Fax: 815-986-2275
info@trinitydaycare.com
www.TrinityDayCare.com

Packet Contents

- Enrollment Form
- Emergency Medical Release Form
- Social Sheet
- Consent to Use Name and/or Photos
- Screenings Consent
- State of Illinois Certificate of Child Health Examination (physical form)
- Trinity Day Care Payment Policies
- Illinois State Board of Education - Child and Adult Care Food Program (CACFP)
- Child Care Assistance Program (CCAP) Application, if applicable (please allow 10 business day for processing)

  Completed application, parent/guardian verification of employment and/or school schedule

The following must be received 2 business day prior to start date.

Please check off to make sure you have all required documentation:

- ☐ Completed enrollment packet
- ☐ Child's certified copy of birth certificate
- ☐ Child's current physical (including immunizations and lead screening)
- ☐ Payment
- ☐ Work Letters / School Schedule (must include hours)
- ☐ Copy of approval letter for parents participating in the Child Care Assistance Program (CCAP)
- ☐ Additional for foster parents
  - ☐ Completed DCFS childcare payment application
  - ☐ Copy of custody arrangements and visitation schedule

Trinity Day Care

"Working Together to Provide a Secure, Nurturing, Educational Environment for Children and Families."

Office Use Only
Expected Start Date: _____
Classroom Number: _____

Enrollment Form

Child Name: _____ Age: _____ Birth Date: _____ Male/Female

Please circle and/or fill in all of the applicable enrollment information below.

Enrollment Type: Infant Toddler Preschool Preschool (ABeka) School Age

Days Attending: Monday Tuesday Wednesday Thursday Friday

Average Daily Drop-Off Time: _____ Average Daily Pick -Up Time: _____

School Age Specific Information

My child will attend: before school, after school, no school days, during school year breaks, summer camp

Elementary School Name: _____ Grade Level: _____

Bus route number to school: _____ Before school bus pick-up time: _____

Bus route number from school: _____ After school bus drop-off time: _____

Please list any other pertinent transportation, arrival/departure, enrollment schedule information here:

The following must be turned in 2 business days <u>before</u> start date:

- Completed enrollment packet
- Child's certified copy of birth certificate
- Child's current physical (including immunizations and lead screening)
- Payment
- Additional for parents participating in the Child Care Assistance Program
    - Completed CCAP application
    - Parent/guardian verification of employment and/or school schedule
- Additional for foster parents
    - Completed DCFS childcare payment application
    - Copy of custody arrangements and visitation schedule

Parent Name: _____ Signature: _____ Date: _____

Additional Enrolling Parent/Guardian Information (optional):

Parent Name: _____ Signature: _____ Date: _____

Revised 1/2020,9/2021 5/2022, 8/2022,6/2023, 2/2024, 5/2024

Behavior Guidelines Policy

Objective:
To provide a secure, nurturing, and educational environment for children, families and staff. Avoid or eliminate unsafe, inappropriate or disruptive behavior practices elicited by a child.

Scope:
Inappropriate or unsafe behaviors include (but are not limited to): hitting, biting, kicking, pinching, willful and inappropriate urination or defecating, inappropriate sexual aggression toward other children, throwing furniture, tipping furniture over, aggression toward staff, spitting, running out of the classroom, throwing/spitting food, eating food off of other children's plates, *harming the physical environment*, refusing to cooperate with redirection, and/or *any other behavior that is detrimental to the individual child or the group.*

Responsibility:
S*taff members are responsible for facilitating Trinity Day Care's "A Positive Approach to Discipline" policy and the following guidelines to achieve the objective.* The staff member in charge of a child at the time of an occurrence is specifically responsible for completing a behavioral report. A copy of the behavioral report shall be given to the parent/guardian. *Parents are responsible to act in partnership with staff to promote our objective and the success of the child(ren).*

Behavioral Guidelines:

1. The child will be redirected from the above mentioned behavior in the classroom. The child may be redirected to a different activity or the problem solving area. The problem solving/quiet area is a quiet place in the classroom where the child can reflect on different ways to handle the situation at hand.
2. If unsuccessful, the child may be visited by *support* personnel to provide further assistance to help the child resume displaying appropriate behavior. The parent may be notified by an office personnel or the child's teacher at this point.
3. If the child's inappropriate behavior continues and he/she is not able to be successful in his/her classroom, the parent will be required to pick up the child immediately.
4. If the child's inappropriate behavior is ongoing, a meeting will be set up to discuss the issues and create a plan to support the child's success. This plan may be revisited to assess the child's progress and/or if it is deemed unsuccessful. Behavior plans may need to be revised several times before finding the most successful strategy for an individual child and require parent participation.
5. After these attempts have been made to meet the child's individual needs and the child continues to demonstrate inability to benefit from the type of care offered at Trinity Day Care, or whose presence is detrimental to the group, the child shall be discharged from the day care. In the event of discharge the center will provide referrals to other agencies *and support a successful caregiving transition.*

I understand and agree to the guidelines of this policy for my child, _____,
and the expectation of my support and participation to his/her success. *child's name*

Parent Signature: _____ Date: _____

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Emergency Medical Release Form

Child Name _____ Birthdate _____/_____/_____
Last First Middle Month Day Year

Address_____ Phone _____
Number and Street City Zip

The child is male ___ female ___ and lives with Mother ___ Father ___ Guardian _____
Please specify relationship if guardian.

Mother/Guardian Name _____ Cell # _____ Work # _____

Birthdate _____/_____/_____ Place of Employment _____ Email Address _____

Father/Guardian Name _____ Cell # _____ Work # _____

Birthdate _____/_____/_____ Place of Employment _____ Email Address _____

Emergency Contacts and Pick-up List: List at least two individuals authorized to pick-up your child that we can call if you are unable to be reached in case of an emergency.

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Additional contact or pick up instructions/information: _____

_____

_____

Child's Doctor _____ Preferred Hospital_____

Special health/allergy considerations apply for my child: ☐ YES ☐ NO If yes, provide additional information.

I do hereby authorize Trinity Day Care to contact directly the persons named on this form, and do authorize the named physician or his associates to render such treatments as may be deemed necessary in an emergency, for the health of the said child. Trinity Day Care is further authorized to take whatever action is deemed necessary in the judgement for the health of foresaid child. I have read and agree to the above statement as it is written.

_____

Parent Signature Date Parent Signature Date

Revised 1/2020,9/2021 5/2022, 8/2022,6/2023, 2/2024, 5/2024

Trinity Day Care

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I (We), _____, the parent(s) of _____
print parent's name(s) above print child's name above

hereby certify that I (we) have received, understand and agree to comply with the following.

Verification of Receipt:

- Trinity Day Care/TDC School Age Program Parent Handbook
- Parent Communication Flyer
- Behavior Guidelines Policy
- Child Care Food Program Brochure (CACFP)
- Food Policy
- Screening and Assessment
- Photo Release
- DCFS Licensing Standards Summary
- Payment Policy

Parent Signature Date Parent Signature Date

Permission Agreement:

→ I give permission for my child(ren) _____ to leave the center with qualified daycare staff and participate in daily walks/visits to nearby parks, special events, faith based programming, and fieldtrips.

→ I understand that Trinity Day Care will share information about my child with DCFS as required by licensing.

→ I agree to act in support of Trinity Day Care's mission, working together "to provide a secure, nurturing, educational environment for children and families."

→ I understand that my child's attendance is required to be at least 80% of the days enrolled on a monthly basis.

→ In consideration of the participation in Trinity Day Care and/or TDC School Age programs and the use of Trinity Day Care's premises and facilities by the minor(s) named above, I hereby agree to release and indemnify Trinity Day Care, its officers and directors, agents, landlords, affiliated companies or organizations, and employees from any and all claims for property damage or loss, injury, or death which the minor(s) may suffer in any way connected with the Trinity Day Care program, including travel to and from the day care and/or its activities. I accept full responsibility for all medical expenses incurred as a result of the minor's participation in Trinity Day Care's day care programs and his/her use of Trinity Day Care's premises and facilities, and I agree to indemnify and hold harmless Trinity Day Care from any claim brought by or on behalf of the minor. This release and indemnity agreement is applicable to any claim based upon negligence and any other theory of recovery, except claims based upon willful or intentional misconduct. I further agree to release and indemnify Trinity Day Care and all other individuals and entities noted above from any and all liability which might result from an act or omission by the minor(s) named above. I also agree that all disputes between myself or the minor(s) named above and Trinity Day Care arising from my/our use of Trinity Day Care's facilities or services will be governed by the laws of the State of Illinois and the exclusive jurisdiction therof shall be in the state courts of the State of Illinois, and the venue for these disputes shall be in Winnebago County, Illinois. If any part of this contract is determined to be unenforceable for any reason or in any circumstance, it is intended that all other terms will be enforceable.

→ I HAVE CAREFULLY READ THIS RELEASE AGREEMENT, ALL OF ITS TERMS AND UNDERSTAND IT.

→ I verify that I am the parent/guardian of the above listed minor(s). I agree to be bound by the terms of this agreement.

Parent Signature Date Parent Signature Date

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Office Use Only

Expected Start Date: _____

Classroom Number: _____

Social Sheet

Child Name: _____ Nick Name: _____

Mother/Guardian Name: _____ Lives with Mother YES ☐ NO ☐

Father/Guardian Name: _____ Lives with Father YES ☐ NO ☐

Custody and Visitation Arrangements:

Provide details such as visitation schedules (or lack thereof), special/temporary living arrangements, custody changes, other major life changes, etc. that may be helpful to us in understanding your child and providing him/her with nurturing care.

_____

Who else lives in the home with the child and what are their ages?_____

_____

Circle all that apply below.

Previous caregiving experiences: None Close friend/relative One on one

Small group care (less than 10 children) Daycare home Daycare center Other_____

What challenges and/or successes has your child experienced with other caregiving or social situations with other children?

_____

When does your child experience regular routines and behavior expectations at home?

Breakfast Lunch Snack Dinner Nap Bedtime Playtime/pick-up Reading time

Bathing procedures Trips/visits All the time Most of the time Other _____

What type of discipline do you use at home?

Praise/Positive Reprimand Time Out Loss of Privileges Physical Discipline Logical Consequences

Strict Permissive Set clear expectations Loving/affectionate Encourage use of language

Further explanation about discipline that may be helpful for us in working with your child:_____

_____

Do you feel successful with the discipline techniques you are using? ☐ YES ☐ NO

Who are the primary disciplinarians? _____

_____ Do their styles match? ☐ YES ☐ NO

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Does your child have any known allergies or asthma? ☐ YES ☐ NO

If yes, please see the office for allergy form ISBE 67-44, which is required in order for us to provide special accommodations.

Please describe allergy and accommodations needed:_____

Does your child receive any special services or have any special needs? ☐ YES ☐ NO

If yes, please describe._____

Does your child nap? ☐ YES ☐ NO

If yes, please describe the routine and normal length of nap_____

_____

Does your child have a "fussy" time or certain triggers that we should be aware of?

_____

Is your child fully potty trained? ☐ YES ☐ NO If NO, circle the items that apply for your child below.

Not ready Started potty training Has occasional accidents Needs bathroom reminders Indicates bathroom needs

Needs a diaper at nap only Other applicable information: _____

Please summarize your child's likes, dislikes, fears, abilities, temperament, play habits, etc.

_____

_____

What do you want your child to gain from his/her experience while attending?

_____

Infant/Toddler/Special Needs Feeding and Eating Information (Circle all that apply.)

Feeding Schedule: every ____ hours five times a day four times a day three times a day

If breast milk or formula feeding, please specify how many ounces per feeding: _____ Other: _____

Feeding Style: On an adult's lap/held In a high chair/booster Independently Spoon/hand fed

Additional Information: _____ **Eats with:** hands utensils both

Drinks from: warm bottle room temp bottle cold bottle breast fed cup with a lid cup with no lid

Food/Drink Type/Tendencies: Eats Baby Food Eats Table Food Drinks Breast Milk

Drinks Formula Drinks Whole Milk Drinks Cow's Milk Drinks juice Drinks Water

Picky Eater Very good eater-asks for more Eats most of his/her food

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Consent to Use Name and/or Photos

The use of children's pictures in Trinity Day Care's educational efforts, marketing and social media activities is valuable for many reasons. We all know people are visual and the use of children's pictures promotes interest in our center, which facilitates relationship building. Developing positive, meaningful, long lasting relationships is critical for Trinity Day Care's long term success, which is why we are asking for your help.

I, _____, hereby give **Trinity Day Care, Inc.** the absolute right, until revoked in writing, to use my child's name, quotes and/or photos and images on the Internet (World Wide Web), in print publications, video and multimedia presentations, and/or for any purpose which may include, but not limited to display, public relations, marketing, or designs. I understand that my child's name and/or the images may be used for display or advertisement for the web site and/or literature published. I hereby waive the right to inspect or approve the images prior to any form of usage. I understand that the images may be modified to be used as design elements.

This agreement allows Trinity Day Care, Inc. to use any images, quotes and/or my child's name for any publishing purposes in the promotion of Trinity Day Care, Inc. and its nominees. I will not hold Trinity Day Care, Inc. responsible for any use or misuse of my name, quotes and/or the images. I agree to hold harmless Trinity Day Care, Inc., its agents or successors in interests from any and all actions, claims, and demands a rising out of or in connection with the use of all or any part of the photographs (including computer images or reproductions of any kind), including any editorial or comment which may accompany the images in their displayed format and/or my name. I will not hold Trinity Day Care, Inc., its agents or successors in interest, liable for any errors/negligence in the editing or displaying of said images, quotes and/or in the use of my child's name.

By signing this agreement, or by signing this agreement on behalf of a minor in the state of Illinois, I am giving Trinity Day Care, Inc. the right to use my child's name and own the images and use them for any purposes without further approval from me. I am releasing all rights to any images. Should I revoke this consent in the future, I understand that the revocation does not apply retroactively, and that any images previously used with prior consent in publications, advertisements, or promotions, will remain unchanged and in use at the discretion of the directors and managers of Trinity Day Care, Inc.

Child/Minor Name _____ Date of Birth _____

Parent/Legal Guardian Name _____

Parent/Guardian Signature _____ Today's Date ____

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Ages & Stages Questionnaires (ASQ-3/ASQ-SE) – Notice and Consent

It is important that we work to ensure each child's development is proceeding without problems during these crucial early years. Developmental screening is a way for us to accomplish this and assist you in monitoring your child's growth and development.

Trinity Day Care will conduct developmental screening for your child, between the ages of six weeks and five years old before entering kindergarten using the Ages and Stages Questionnaires (ASQ-3 and ASQ-SE). Screenings are conducted within the first few months of enrollment and approximately every four months thereafter until early preschool (2 1/2 years old), where they will be screened yearly until kindergarten. Parents are given copies of the teacher completed assessment questionnaires and are encouraged to discuss results with the teachers. Parents may also request a blank Ages and Stages Questionnaire of their own to complete, which is the ideal situation. Then, parents and teachers can share and compare information about the screening in the best interest of the child.

Most of the time, children will score in the normal or higher range of development for their age. There will be sometimes when a child is not in the normal range of development. When this happens, we need to take prompt action in the best interest of the child. If a child's development is significantly below the normal range, a referral is required. By law, our professionals have seven days to report a significant delay to a referral agency (i.e. Child and Family Connections). Teachers are required to refer a child through their professional observation or by sending in the Ages and Stages Questionnaire. We hope our screening process helps you to better understand your child's developmental milestones and builds stronger parent-teacher relationships to promote the success of your child.

Acknowledgement and Statement of Consent

I have read and understand the developmental screening process noted above. I understand the purpose and intent of the screening. Please check the box that applies that to your position in regards to consent

☐ ***I give my informed consent*** for Trinity Day Care to carry out the described developmental screening process for my child.

☐ ***I do not give my consent*** for the developmental screening to be administered for my child and I do not wish to participate in the screening process. There will be no future claims made against Early Care and Education Practitioners, the Early Intervention Services System, or the local public school system.

_____

Parent/Guardian Signature Date

Consent for Release of Information

I further understand that Part C of individuals with Disabilities Education Act (IDEA) mandates that childcare providers refer the identification of a possible delay to Child and Family Connections (CFC) within seven days of recognition of a delay. Please check the box that applies that to your position in regards to consent for release of information.

☐ ***I, therefore, consent to the release of the ASQ-3/ASQ-SE or any other necessary information pertaining to my child's development by Trinity Day Care*** to CFC about my child in the event it is identified that my child may have a developmental delay or disability in order to seek appropriate early intervention support services.

☐ ***I do not consent to the release of my child's ASQ-3/ASQ-SE screening results or related information*** to the CFC, but understand my child's teachers are still required, by law, to make a verbal referral to CFC and that someone may contact me about the teacher's developmental concerns. There will be no future claims made against Early Care and Education Practitioners, the Early Intervention Services System, or the local public school system.

_____

Parent/Guardian Signature Date

Revised 1/2020,9/2021 5/2022, 8/2022,6/2023, 2/2024, 5/2024

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#

Address (Street / City / Zip Code) | Parent/Guardian | Telephone # Home / Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap, **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, , Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

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Trinity Day Care Payment Contract

Fee Structure

Under 2 .....$62.00 daily / $310.00 weekly
2 years old.....$50.00 daily / $250.00 weekly
3 to 12 years old - all day .....$42.00 daily / $210.00 weekly
School Age .....$22.00 daily / $110.00 weekly

Payment Policy

- **Payment is due in advance of service in order for your child(ren) to attend. The first month of tuition is due prior to attendance.**
- Full payment is required regardless of attendance with the exception of vacation (1 week per child per calendar year). Vacation week may be used after 90 days of enrollment.
- A processing fee of 2.6% will be accessed for credit and debit card payments.

Payment Options

- Automatic Payments: Your full payment for the upcoming month is drafted from a bank account or credit card on the last day of the current month. See the office to request the secure link for Procare Automatic Recurring Payment Request to be sent to you.
- Online Payments: Make payments on your account at any time using MyProcare.com. Open a browser window, go to MyProcare.com and follow the instructions to create an account. The Procare App is not able to process payments.
- Front Desk: Cash, Check and Credit/Debit Cards can be paid at the front desk. Cash – We do not offer change for cash payments. Any over payments will apply to the next balance on your account.

Communication is the key. Our business office is open from 6:30 a.m. to 5:30 p.m. to help you and your family work out the best possible options/solutions to meet your needs when it comes to childcare services.

Cancellation of Services: A two-week notice is required to cancel services at Trinity Day Care. If a two-week notice is not given, we reserve the right to charge you for the two weeks.

Additional Service: For unexpected hardships of a more significant nature, a charitable grant application is available and funding is offered on a limited basis for those who apply.

Monthly Payments are due by the 1st business day of the month for the entire month of service.

I, _____, understand and agree to comply with this payment contract. I
(Print Name)
understand that I am ultimately responsible for the day care cost. I understand that in the event any unpaid balance is placed for collections, with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, all collection fees, attorney fees, filing fees, interest, and court costs will be added to the total amount due.

_____ _____
Signature Date