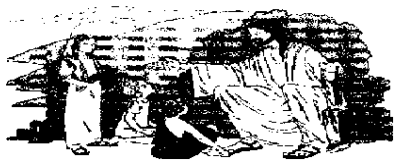

Open Arms Learning Center
222 E. Wade St
Mountain Home, AR 72653
(870) 424-5758

Child's Name:_____ **Birth Date:**_____
Allergies:_____ Medical Conditions:_____
Home Address:_____ Home Phone:_____
City:_____ State:____ Zip Code:_____

Days of the Week Scheduled (Circle): M T W TH F
Method of Tuition Payment (Circle): Private - DHS - ABC - Pathways

Father's Name:_____ (Lives with child) Yes____ No____
Cell Phone:_____ Work Phone:_____
Father's Employer:_____ Work Hours:_____ to _____
DL#:_____ Social Security#:_____
Father's Signature:_____ Date:_____

Mother's Name:_____ (Lives with child) Yes____ No____
Cell Phone:_____ Work Phone:_____
Mother's Employer:_____ Work Hours:_____ to _____
DL#:_____ Social Security#:_____
Mother's Signature:_____ Date:_____

Persons (other than parent/guardian) authorized to pick up the child from the center:

Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____

Child's Physician:_____ PH#:_____
Address:_____ City:_____ State:____

Enrollment Date:_____

Emergency Medical Consent:

I, _____ Father – Mother – Guardian (circle one) of _____ (child's name) do hereby give my consent to the Director of **Open Arms Learning Center** or his/her duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed recognized physician or surgeon in case of an emergency when the parents or guardian cannot be reached. I also give consent for the Director or his/her duly appointed representative to transport said child for emergency medical treatment. I have also submitted an updated immunization record for my child.

Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

Hippa:

I, _____ the parent/guardian of _____ give permission for my child's allergy or allergies to be posted in **Open Arms Learning Center** on classroom walls, in the kitchen and other areas as may be needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Sunscreen:

My child has permission to have sunscreen applied to exposed areas on hot sunny days. I understand that sunscreen will be provided by the center and that if my child has an allergy to any brand of sunscreen, I will provide sunscreen for my child.

Developmental Screening:

Children ages birth through 3 years of age will be screened annually free of charge using the ASQ and children 3 years of age and older will be screened through O.U.R. Educational Cooperative.

Photography:

I give permission for **Open Arms Learning Center** to photograph my child and display photographs throughout the center. I also give permission for my child's photographs to be utilized in an education manner for training purposes and to be submitted to the Baxter Bulletin for special occasions to inform the community about the Open Arms Preschool program.

Shaken Baby Syndrome:

I have received the brochure on Carter's Law from Open Arms Learning Center.

Discipline:

I understand that Open Arms Learning Center has the goal to help children learn acceptable behavior and develop self-control. By signing below you are agreeing the to the discipline policy as stated in the handbook.

Handbook for Families:

I have received, read, understand the handbook of **Open Arms Learning Center** and agree to adhere to the said policies and procedures.

Parent/Guardian Signature:_____ Date:_____

ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: CHILD'S NAME **Client ID #:**
Mailing Address: **Date of Birth:**
Case Head:

I, PARENT/GUARDIAN hereby authorize
(Client or Personal Representative)

Jill Wilson to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: DAYCARE NAME Open Arms Learning Center
222 East Wade Ave
Mountain Home, AR 72653
P:(870)424-5758 F:(870)424-7437
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): IMMUNIZATION REQUIREMENTS

Specific information to be disclosed: SHOT RECORDS
"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: January

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

(Signature of Client)	*(Date)*	*(Witness-If Required)*
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ *(Date)* _____ *(Signature of Staff)*

Behavior Guidance Discipline Policy

Our goal is to help children learn acceptable behavior and develop self-control. Our program is designed to promote positive and enjoyable learning experiences and to build trusting, respectful relationships. A well-planned schedule, classroom arrangement, and curriculum, along with well-trained staff, significantly reduces instances of inappropriate behavior. However, when children do make mistakes in behavior, we use the following guidance techniques.

- Tell the child what he/she CAN do
- Give chioices whenever possible, but only when the child really has a choice
- Support children in learning to solve their own problems and work out conflicts
- Re-direct a child to another activity
- Help the children learn how to play with friends

Physical punishment and threats are never used by our staff. Teachers will provide schedules and maintain curriculum to reinforce positive behavior.

Limits of Behavior

Respect others.
Repect yourself.
Respect toys and equipment.

Guidance Policy

At enrollment, parents will be given a written copy of our behavior guidance policy. Parents will also sign an acknowledgement that they have been informed of the policy.

Pattern of Inappropriate Behavior

When a pattern of inappropriate behavior emerges, parents are required to meet with our staff. The goal will be to work together to find a solution to the problem behavior and resolve the difficulty. If outside professional consultation or evaluation is necessary, the center director will invite an appropriate consultant to join the parent-staff partnership.

In cases of biting, if the child bites three times or attempts to bite three times, the parent will be called and the child will be removed from the center for the remainder of that day. If biting continues to be an issue the situation will be reviewed. If all attempts to change that behavior are unsuccessful, we will refer to number 3 on the child dismissal policy.

Child Dismissal

The director reserves the right to dismiss any child.

A child may be dismissed if

1. The parent or child refuses to follow the policies and procedures of the center.
   This may include situations in which repeated requests for updated immunizaion records, emergency contact information, required paperwork, etc. are ignored by parents.
2. Center staff is not able to meet the needs of the child for any reason.
3. The child becomes an endangerment in any way to other children or the staff
   It is not the intent of the director to dismiss any child; every reasonable effort will be made to ensure that dismissal is not necessary.

Please know that No child shall be dismissed from ABC without Division approval for behavior.

Please Sign and Date_____

Dear Parent/Caregiver:

Welcome to our screening and monitoring program. Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. As part of this service, we provide the Ages & Stages Questionnaires, Third Edition (ASQ-3), to help you keep track of your child's development. A questionnaire will be provided every 2-, 4-, or 6-month period. You will be asked to answer questions about some things your child can and cannot do. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal-social skills.

If the questionnaire shows that your child is developing without concerns, we will provide some activities designed for use with ASQ-3 to encourage your child's development and will provide the next questionnaire at the appropriate time.

If the questionnaire shows some possible concerns, we will contact you about getting a more involved assessment for your child. Information will only be shared with other agencies with your written consent.

We look forward to your participation in our program!

Sincerely, Jill Wilson

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

◯ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

◯ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____
Parent's or guardian's signature

_____
Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____

ASQ-3™

Provider's Initial: _____

Date: _____
(form valid for one year from this date

CHILD CARE FOOD PROGRAM
ENROLLMENT FORM
(to be completed by parent or guardian)

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

Jill Wilson
Name of Provider/Director

(870) 424-5758
Telephone

Open Arms Learning Center
Name of Day Care Facility

222 E. Wade Ave.
Address Mountain Home, AR 72653

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child(ren) will be served the following meals:
(Please Circle) (Breakfast) AM Snack (Lunch) (PM Snack) Other _____

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days of Week (circle)	Sex
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F

Note here any food allergies or special needs your child(ren) have: _____

Doctor's Name: _____ Doctor's Telephone: _____

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____

(enroll-2007)

Please see the instructions on the reverse side if you have questions, or you may call the center. #

1. PRINT: Child Information

> _____ ____ Open Arms Learning Center
CHILD/CHILDREN'S NAME(S) AGE NAME OF CENTER/PROVIDER

> _____ ____

> _____ ____ Number of children claimed on this application _____

> _____ ____ 2. List the **Supplemental Nutrition Assistance Program (SNAP) number**, if any, then skip to #5

> _____ ____ # _____

3. **FOSTER CHILD:** List the child's monthly personal use income. Write "0" if the child has no personal income.$ _____

4. **HOUSEHOLD MEMBERS AND MONTHLY INCOME:** If you gave a Food Stamp case number for the child PART 2, skip to PART 5.

NAMES OF HOUSEHOLD MEMBERS	Gross MONTHLY Earnings (before deductions) JOB 1	JOB 2	Monthly Welfare Payments, Child Support, Alimony	Monthly Pension/ Retirement Payments, SS Income	Any other Monthly Income
_____	$ _____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____	$ _____

5. **SIGNATURE AND SOCIAL SECURITY NUMBER:** I certify that all the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal Funds; that center officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X _____ #_____
Signature of Adult Household Member **LAST 4 DIGITS ONLY** - Social Security Number*

Home telephone # _____ Work telephone # _____ Printed name _____

Street/apt # _____ City/state/zip _____ Date _____

6. **RACE:** Please circle the racial or ethnic identity of your child. You are not required to answer this question.
White Black or African American Hispanic or Latino Asian Hawaiian Native or Other Pacific Islander
American Indian/ Alaskan Native Not Hispanic or Latino

* **PRIVACY ACT STATEMENT:** Section 9 of the National School Lunch Act requires that, unless your child's Supplemental Nutrition Assistance Program (SNAP) is provided, you must include the las 4 digits of the Social Security number of the adult household member signing the application or indicate that the household member does not have a Social Security number. Provision of Social Security number is not mandatory, but if a Social Security number is not given or an indication is not made that the signer does not have such a number, the application cannot b approved. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of the information stated on the application. Thes verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or welfare office t determine current certification for receipt of SNAP benefits , contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss of reduction of benefits, administrative claims, or legal actions if incorrec information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptrolle General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, state and local education, health, and nutrition programs.

FOR CENTER/PROVIDER USE ONLY **DO NOT WRITE BELOW THIS LINE**

MONTHLY INCOME CONVERSION: WEEKLY X 4.33 EVERY TWO WEEKS X 2.15 TWICE A MONTH X 2
TOTAL HOUSEHOLD SIZE _____ MONTHLY INCOME _____ CHECK IF SNAP PARTICIPANT_____
Eligibility Determination: APPROVED FREE _____ APPROVED REDUCED PRICE _____ DENIED _____ Temporary: FROM _____ TO _____
REASON FOR DENIAL: INCOME TOO HIGH _____ INCOMPLETE APPLICATION _____ OTHER : _____
CHANGE IN STATUS: _____ REASON: _____ DATE: _____ DATE WITHDRAWN: _____
SIGNATURE OF DETERMINING OFFICIAL: _____ DATE: _____

[Form valid for one (1) year from this date]

Open Arms Learning Center
222 E. Wade Ave.
Mountain Home, AR 72653
(870) 424-5758

Noah's Ark Preschool
202 Springwood Ave.
Mountain Home, AR 72653
(870) 425-6204

Tuition Chart
Effective January 2016

Hours of Operation
Open Arms
&
Noah's Ark
6:00am – 5:30pm

A one time $40.00 registration fee is due upon enrollment (half price for additional children)

INFANTS/TODDLERS (6 weeks – 3years)
$23.00/Day - $115/week

Half-Day Rate
$13.00 - 4 Hours or less
*(excluding lunch)

PRE-SCHOOL (3years – 5years)
$19.00/day-$95/week

Half-Day Rate
$10.00 - 4 Hours or less
*(excluding lunch)

SCHOOL-AGE (full time)
$20.00/day-$100.00/week

Half-Day Rate
$10.00 - 4 Hours or less
*(excluding lunch and field trip)

SCHOOL-AGE (full time)

Before school only	$4.00/day - $20.00/week
After school only	$8.50/day - $42.50/week
Before and after	$12.50/day - $62.50/week

*** Tuition is due each Friday for the next week of service. **Policy is to pay whether your child is here or not.** A late fee of $15.00 will be assessed to your account if tuition is paid any later than Monday afternoon or if you pick up your child any later than 5:30 p.m. (an additional $10.00 for every 15 minutes after that).
***The following will be paid holidays. No childcare service will be provided: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve & Christmas Day.
***Hours of operation may be shortened due to inclement weather. You will not be charged if the center is unable to open.

*** Any day which your child either attends over 4 hours or eats lunch will be considered a full day.

Parent/Provider Contract

Child's Name:_____ Enrollment Date:_____

Days: M T W R F Hours:_____ Weekly Tuition:_____

By signing this agreement, you are accepting all terms. _____
Parent Signature

(Revised Jan 2016 – JW)