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

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

Child's Name:____________________________ **Birth Date**:____________________
Allergies:________________________________ Medical Conditions:____________
Home Address:____________________________ Home Phone:________________
City:____________________________________ State:____ Zip Code:__________
Email address:_____________________________ **Enrollment Date:**_____________

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

Father's Name:__________________________ (Authorized to pick up child) Yes____No____
Cell Phone:______________________________ Work Phone:___________________
Father's Employer:_________________________ Work Hours:________ to _________
DL#:____________________________________ Social Security#:_______________
Father's Signature:_________________________ Date:__________________________

Mother's Name:__________________________ (Authorized to pick up 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:____
Insurance Carrier:____
Please tell us about any beliefs, culture or childbearing practices your child might have:
____

We are an equally opportunity provider.

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: I give written permission for sunscreen to be 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. Permission must be given yearly.

Developmental Screening: Children ages birth through 5 years of age will be screened annually free of charge using the ASQ.

Special needs: I have been informed in writing that all childcare facilities are required by IDEA to refer a child with any suspected delays or disabilities to the appropriate lead agency (as determined by the child's age).

Photography and video permission: I give permission for **Open Arms Learning Center** to photograph/video my child and display photographs/videos throughout the center. I also give permission for my child's photographs/videos 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 and on the Facebook page and/or website.

Photos/Video recordings permission on Social Media/Websites: I give permission for photographs or video recordings of my child to be placed on social media or any other web-sites. This is in accordance with Minimum Licensing Requirements.

YES __________ or NO____________ please check your preference.

Shaken Baby Syndrome: I have been offered the brochure on Carter's Law from Open Arms Learning Center. (www.purplecrying.com)

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. No physical punishment shall be administered.

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.

Interviews by DHS and Other Agencies: Any staff member or children in attendance may be interviewed by Child Care Licensing, by the Division of Child and Family Services, and/or by law enforcement officers for the purpose of investigations or to determine compliance with licensing requirements. Child interviews do not require parental notice or consent.

Kindergarten Readiness Skills: I have received information of Kindergarten Readiness Skills Calendar for my child (Only for children ages 3 and 4 years old).

Medical Homes: I have received information of medical homes for children for my provider.

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:___________

We are an equally opportunity provider.

Disease History (list the dates of each)

Measles_______ Mumps_______ German Measles_______ Chicken Pox_______

Whooping Cough_______ Contracted Tuberculosis ______yes ______no

Frequent ear infection ____yes ____no Frequent throat infections ____yes ____no

Medications ____________________Allergies______________________________

Other conditions or comments:____

Developmental Needs

Physical or emotional problems the child may have: __________________________

Child's special food needs:____

Special Information

Temper tantrums___ Diabetes___ Frequent colds___ Biting___ Sun Sensitivity___ Seizures___

Fainting spells___ Bed wetting___ Other________________________

Requires help with:Dressing__ Undressing__ Toileting__ Eating__ Hand washing__

Is the child toilet trained? ___yes ___no Toileting words used _______________

Favorite games___________________ Favorite toys_________________________

Siblings ___yes ___no Names & Ages_____________________________________

Type of childcare used before____

Special Customs or Beliefs ____

Other useful information about your child__________________________________

Does your child have health insurance ________ yes _______ no

If yes, who is your health insurance carrier_________________________________

We are an equally opportunity provider.

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.

<u>Limits of Behavior</u>

Respect others.
Repect yourself.
Respect toys and equipment.

<u>Guidance Policy</u>

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____

ARKANSAS DEPARTMENT OF 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)

Open Arms Learning Center, INC. or Noah's Ark Preschool to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to:

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

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): IMMUNIZATION REQUIREMENTS

Specific information to be disclosed: ______
ing my health care

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you 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 you.

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)*

Parent Questionnaire
Help us to know about your child!

1. child's FULL name: ______________________________ DOB ______________
2. parent's or guardian's names and numbers:

mom: ____________________ phone: ____________________ lives with: yes O no O
mom work: ____________________ phone: ________________
dad: ____________________ phone: ____________________ lives with yes O no O
dad work: ____________________ phone: ________________
siblings names and ages:
____
any allergies: yes O no O if yes what are they ______________________________
special medical conditions: ______________________________
any languages besides English spoken at home:
yes O no O if yes what language: ______________________________
What are two goals you have for your child for this school year?
1. ____
2. ____

Tell us about your child!
favorite toy: ________________ favorite food: ____________________
pet/pets: ______________________________ favorite color: ____________
favorite outdoor activity: __________ favorite family activity: ________________
favorite book: ________________
any special assistance they may need:
____

What would you like us to know? (describe your child)
____
____
____
____
____
____
____
____
____
____

parent/guardian signature: ____________________ date: ________________

Thank you for taking the time to tell us about your child and welcome to Open Arms Learning Center!

PARENT AGREEMENT

For the Use of Non-standard Playground Items/Activities

My child care provider ____________________ has discussed the "plan-of-use" that is attached to this agreement. This plan covers the intended use of playground items/activities that are not commercially manufactured and therefore have not been certified as safe for playground activities and have no manufacturer's installation instructions or recommended use guidelines. Because of this, these items/activities involve some degree of added risk. The plan for each activity has been discussed with me and I understand the risks involved. The Child Care Licensing Unit has reviewed the equipment/activities outlined in this plan and has approved the plan based on the providers agreement that the plan will be implemented and supervised as specified in the plan. The Child Care Licensing Unit will monitor these items/activities to ensure on-going compliance with all of the terms and conditions of the plan.

The use of all items/activities covered by this plan has been explained to me and I have received a copy of the approved plan. Based on this information, I am in agreement that any possible risk to my child is acceptable to me.

I agree to allow my child ______________________________to participate in the listed activities.

____ _________________________

Parent Signature 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,

Director OALC

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: ________________________

Special Nutrition Program
Child and Adult Care Food Program
Letter to Parents

Dear Parent/Guardian,

Open Arms Learning Center, INC participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps/SNAP, then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form, including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If food stamp/SNAP case number is not reported, you must complete Sections 4 and 5 on the eligibility statement. Section 4 should include the name of **all** household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use last year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds $50 per month or $600 per year. If you list a food stamp/SNAP case number, you must notify us when you no longer receive food stamps/SNAP. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

USDA Child Nutrition Program Income Guidelines

Household Size	Weekly Income	Bi-Weekly Income	Twice Monthly Income	Monthly Income	Annual Income
1	$365	729	790	1,580	18,954
2	$493	986	1,069	2,137	25,636
3	$622	1,243	1,347	2,694	32,318
4	$750	1,500	1,625	3,250	39,000
5	$879	1,757	1,904	3,807	45,682
6	$1,007	2,014	2,182	4,364	52,364
7	$1,136	2,271	2,461	4,921	59,046
8	$1,264	2,528	2,739	5,478	65,728
Each additional household member add	+$129	+257	+279	+557	+6,682

This Institution is an equal opportunity employer and provider.

Provider's Initials: __________

Date: __________

CHILD CARE FOOD PROGRAM
ENROLLEMENT 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 must be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have questions, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

Open Arms Learning Center, INC. DBA: Noah's Ark Preschool DBA Open Arms Learning Center
Name of Day Care Facility

(870) 424-5758
Telephone #

222 E Wade Ave — Mountain Home — AR — 72653
Address — City — State — Zip Code

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 specified below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ☒ AM Snack: ☒ Lunch: ☒ PM Snack: ☒ Supper: ▨ Late Snack: ▨

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	

Please identify any fool allergies or special needs your child(ren) require:

Doctor's Name: ____________________ Doctor's Telephone: ____________________

Revised 07/2022

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

***OPTIONAL* Participant's ethnic and racial identities** **Please select all that apply**

Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

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 (including gender identity or sexual orientation), 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.

EMERGENCY CONTACT INFORMATION:

Home Telephone #: ______________________ Work Telephone #: ______________________

____

Parent's Address City State Zip Code

Parent's Signature: ______________________ Date: ______________________

*Form expires one (1) year from this date

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Open Arms Learning Center, Inc.

Part 1. CHILDREN

NAME OF ENROLLED CHILDREN	AGE	FOSTER CHILD YES - NO	ADDITIONAL HOUSEHOLD CHILDREN	AGE

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:______________________________ CASE NUMBER: ______________________

A Case number is not the number found on the EBT card or an individual's Social Security number.

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, or Migrant Coordinator. Homeless O Migrant O Runaway O

Part 4. Total Household Gross Income: You must tell us how much and how often: example – weekly/monthly/yearly

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: ______________________ Print name: ______________________

Date: ______________ (form valid for one (1) year from this date)

Address: ______________________ Phone Number: ______________

City: ______________________ State: __________ Zip Code: __________

Last four digits of Social Security Number: * * * - * * - _ _ _ _ **(required)** O **I do not have a Social Security Number**

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Open Arms Learning Center, Inc.

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
O Hispanic or Latino	O Asian	O American Indian or Alaska Native
O Not Hispanic or Latino	O White	O Native Hawaiian or Other Pacific Islander
	O Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: ___________ Per: q Week, q Every 2 Weeks, q Twice A Month, q Month, q Year Household size: _________

Categorical Eligibility: ___ Date Withdrawn: ________ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason:

____

Temporary: Free_____ Reduced_____ Time Period: ______________________________(expires after _____ days)

Determining Official's Signature: ____ Date: ______________

If applicable, Sponsor Signature:____ Date:______________

HNP Representative Initials/Date
(for use during CACFP Reviews)

____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced' , or 'Paid".

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

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Tuition Chart
Effective October 1, 2023
Previous Increase January 1, 2021

Hours of Operation

7:00-5:30

A one time $50.00 registration fee is due upon enrollment

INFANTS/TODDLERS (6 weeks – 3years)
$35.00/Day - $175/week — Half-Day Rate $25.00 - 4 Hours or less *(excluding lunch)

PRE-SCHOOL (3years – 5years)
$30.00/day-$150/week — Half-Day Rate $25.00 - 4 Hours or less *(excluding lunch)

Before school only (7:00-8:00a.m.) $5.00/day - $25.00/week
After school only (3:00-5:30p.m.) $10.00/day - $50.00/week

SCHOOL-AGE (K-6th) (full time)
$30.00/day-$150.00/week — Half-Day Rate $25.00 - 4 Hours or less *(excluding lunch and field trip)

SCHOOL-AGE (K-6th)
After school only(3:00-5:00p.m.) $10.00/day - $50.00/week

DROP-IN (based on availability) Must call in advance of 24 hours at minimum to check for spots available.
Any Age $50.00/day

*** 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 $25.00 will be assessed to your account if tuition is paid any later than Monday by 10:00 am or if you pick up your child any later than 5:30 p.m. (an additional $10.00 for every 10 minutes after that).
***The following 10 days will be paid holidays. No childcare service will be provided: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Eve, Christmas Day & New Year's Eve.
***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, which is less than 10 hours of care total per day.
***Although hours of operation are 7:00 am to 5:30 pm, due to ratios we only have limited space available for the early and late hour. Please see the office if you need to adjust time to check for availability.
***Rates will be increase periodically to keep up with the cost of living.

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 Oct 2023 – JW)