



PRESCHOOL PROGRAM CONTRACT

Summary

Child's Name _____

Amount Paid _____

Check # _____ Cash _____ Credit Card _____

Program Year _____ Start Date: _____

THIS AGREEMENT between Jefferson Child Care and Education Center, Inc. ("JCCEC,") and the parent or guardian signing below (the "Parent/Guardian,") for services to the child identified below is executed on the date(s) appearing below and is effective on the date signed by the JCCEC representative who has reviewed the Agreement, as set forth below.

NOW THEREFORE, the parties agree as follows.

1. Services.

The JCCEC Parent Handbook (the "Parent Handbook,") describes the services to be provided by JCCEC, JCCEC's policies, and the obligations of the Parent/Guardian for the Preschool Program (the "Program,").

2. Receipt of Parent Handbook.

The Parent/Guardian hereby acknowledges receipt of a copy of the Parent Handbook and agrees to comply with all of the policies, terms, and conditions contained in the Parent Handbook.

3. Days of Service.

Following are the days of service covered by this Agreement:

(Please Choose One)

___ Five Days

___ Monday, Wednesday, Friday:

___ Tuesday & Thursday

___ Other combination of days: _____

4. Classroom.

Goldfish ___ Mollies ___ Minnows ___

Preschool Guppies ___ Preschool Dolphins ___

Potty Trained (Y) ___ (N) ___

Drop off time: _____ am Pick up time: _____ pm

Pre - K Before ___ Pre - K After ___ Pre - K Before and After ___

Payment of Tuition.

5. Due on Signing. In addition to the tuition for the Program, payment of a registration fee (for new children only), two weeks' tuition as a security deposit, and tuition for the first week of the Program are due upon signing this Agreement. The payment due upon signing is:

$$\begin{array}{ccccccc} \$40.00 & + & & + & & = & \\ \text{Non-refundable} & & \text{Two week security} & & \text{First week's} & & \text{Total due on signing} \\ \text{registration fee} & & \text{deposit} & & \text{tuition} & & \end{array}$$

Based upon the days of service specified above and the current tuition rates, the current weekly fee for the Program for the Parent/Guardian's child is \$_____.

5.1 Tuition Subject to Change. The Parent/Guardian acknowledges and agrees that, while JCCEC uses its best efforts to maintain tuition rates, JCCEC may have to raise the tuition rates from time to time for children attending the Program. The Parent/Guardian agrees that the Parent/Guardian will pay the tuition rates that are in effect during the time that their child is attending the Program.

5.2 Late Pickup. JCCEC's hours of operation are 7:00 a.m. – 6:00 p.m. Late pick-ups will incur a fee of \$1.00 for every minute past 6:00 p.m.

6. Weekly Tuition. The Parent/Guardian agrees to pay the weekly tuition in effect no later than Thursday for the following week. The Parent/Guardian acknowledges and agrees that their child will not be allowed to attend the Program if tuition payment is in arrears, in accordance with the procedure described in the Parent Handbook. There is a returned check fee of \$30.00.

6.1 Overdue Balance and Collection. Overdue balances will be charged interest at an annual rate of 18%. Overdue balances may be subject to collection proceedings. Collection proceedings will include the full balance in arrears, accrued interest of 18% per annum, a late penalty of \$_____, and any and all collection and legal fees.

6.2 Absences and Closures. The Parent/Guardian understands that **no reduction** in tuition will be made for their child's absence due to sickness, vacation, or other causes or when JCCEC is closed for vacation, holidays, or for emergencies beyond JCCEC's control such as, for example, snow days, lack of heat or water at the facility at which the Program is being conducted, which result in the JCCEC facility being closed.

7. Notice of Withdrawal. The Parent/Guardian understands and agrees that JCCEC requires a two week notice of withdrawal from the Program. Failure to provide notice may result in forfeit of the deposit.

7.1 Information Provided by Parent/Guardian. Attached to this Agreement are copies of the information provided by the Parent/Guardian to JCCEC as part of the application for JCCEC's services. The Parent/Guardian confirms that this information is accurate and agrees to inform JCCEC regarding changes in circumstances, and **immediately** in the event of any changes in the emergency information previously provided to JCCEC.

8. **Term.** The term of this Agreement shall be for the Program year identified above. A new agreement must be signed for every Program year.

IN WITNESS WHEREOF, the Parent/Guardian has identified the child below and the parties have executed this Agreement on the dates appearing below.

(Child's Name/Date of Birth)

Signature of Parent/Guardian Date

**JEFFERSON CHILD CARE AND
EDUCATION CENTER, INC.**

Signature of JCCEC Representative Date

Reviewed By Date

EMERGENCY FORM

Child's Name _____ Birthdate _____
 Last First Middle

Address of child _____ Phone _____

City _____ State _____ Zip _____

Child Living With: Both Parents _____ Mother Only _____ Father Only _____ Other _____

(Drop-off or Pick -up restrictions/court orders require Legal Documents)

Mother
Name

Father
Name

Address

Address

Phone

Phone

Cell#

Cell#

E-Mail:

E-Mail:

Place of Business or School

Name

Name

Address

Address

Phone

Hrs.

Phone

Hrs.

Physician

Name _____

Phone _____

Address _____

Insurance Co./# _____

Emergency & Sign Out Names (please print name, signature not required at this time.)

Emergency contacts (an adult that must be available within 30 minutes of calling in case of parent or guardian unavailability)

1. Name
Address
Signature
Phone

2. Name
Address
Signature
Phone

3. Name
Address
Signature
Phone

4. Name
Address
Signature
Phone

Note here any medical problem or allergy _____

I give my permission to Jefferson Childcare & Education Center for the following:

1. To give medical treatment to my child if necessary.
2. For my child to be photographed, taped or filmed and use his./her work for display and publication.

Parent Signature _____

Date _____



I (We) _____
Name(s)

Of _____ do hereby state _____
City County State

That I am (we are) the parents/guardians, having legal custody of _____

Child's Name

A minor, age _____, born _____ who resides with me (us) at _____
Address

I (We) authorize Jefferson Child Care and Education Center, P.O. Box 527: 29 Nolan's Point Rd., Lake Hopatcong, NJ 07849, to consent to an X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general supervision of a licensed Physician or Surgeon.

Dated this _____ day of _____

Signature of Parent (s) or Guardian (s)

Witness _____ Date _____

Existing medical problems of child, in any _____

Existing allergies, if any _____

Child's Doctor _____ Doctor's phone # _____

Specialist _____ Parent's Doctor _____

Medications that child is taking _____

Insurance Company _____ Group _____

** Please attach a copy of your child's medical insurance card **

Identification # _____ Last tetanus shot _____

Provided as a Public Service by
Northwest Covenant Medical Center
Sponsored by the Sisters of Sorrowful Mother

Department of Emergency Medicine:
Dover General Campus, Dover 973-989-3200
St. Clare's, Denville 973-625-6063

Jefferson Child Care and Education Center
Preschool Admissions Form

Child's name _____
Last First Middle Date of Birth

Child's Address _____

Mother's Information _____
Last name First Home address/phone #
Business Name Address Telephone#

Father's Information _____
Last name First Home address/phone #
Business Name Address Telephone#

Cultural Background _____
Home Language

Please list any other adults living in the home _____
Name Relationship
Name Relationship

Other children living at home _____
Name Age Relationship
Name Age Relationship
Name Age Relationship

Pets _____
Type Name
Type Name

Was your pregnancy full term? Yes _____ No? _____
Were there any pregnancy or delivery complications? Yes _____ No _____
Please explain. _____

Is your child allergic to any food or medication? Yes _____ No _____
If yes, please describe _____

Does your child have any interests, abilities, needs which need to be brought to our attention? _____

Does your child have any health issues or special needs? _____

Has your child been in a child care situation before enrollment at our Center? Please describe any past child care experience(s). _____

Does your child experience any particular fears? Yes _____ No _____

If yes, please describe. _____

Has your child recently experienced any change or trauma (ie. Recent move, birth of a sibling, death in the family etc.) Yes _____ No _____. If yes, please explain

How would you describe their current eating habits? _____

Does your child nap regularly? Yes _____ No _____ Describe _____

Thank you for taking the time to share this information with us. Every child is unique and special to us. This information will enable us better to know your child and provide him/her with quality care to fit his very own needs.

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health*

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last)		(First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormalities Noted:			Weight (must be taken within 30 days for WIC)		
			Height (must be taken within 30 days for WIC)		
			Head Circumference (if <2 Years)		
			Blood Pressure (if ≥3 Years)		
IMMUNIZATIONS			<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					



RECEIPT OF INFORMATION STATEMENT

I hereby certify that I have received and read a copy of the Jefferson Child Care and Education Center Parent's Manual which includes the information to parent's statement, as published by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children And Families in addition to the Center policies below:

- Information to Parents Document
- Policy on the Release of Children
- Policy on Dispensing Medication
- Policy on Methods of Parental Notification
- Positive Guidance and Discipline Policy
- Policy on Management of Communicable Diseases
- Expulsion from program
- Policy on the Use of Technology and Social Media

Child's Name _____

Parent's Name _____

Date _____

My child _____ is in good health and can participate in the normal activities of the program.

Please list below any conditions or special needs that may require special accommodations for your child.

Signature of Parent or Guardian



Social Media Release

Social Media is a great way to stay connected! Throughout the year, we will be posting pictures of students during various learning experiences and activities. Personal information will NEVER be shared.

_____ I give permission for my child to be photographed for Jefferson Child Care and Education Center's social media pages.

_____ I DO NOT give permission for my child to be photographed for Jefferson Child Care and Education Center's social media pages.

Student Name

Parent Signature



Dear parents,

We will be implementing our **"One Call System"**.

This system will notify you of Emergency closings, early dismissals, etc.

The following are options you may select from to be notified.

Child(ren) Name: _____

School Attending: _____

Cell Phone _____

Cell Phone _____

Home Phone _____

E- Mail _____

E-Mail _____

If you have any questions please do not hesitate to call.

Lisa Scognamiglio
Executive Director



Authorization to Set Up or Change Automatic Payment

Date: _____

To: Jefferson Child Care and Education Center
29 Nolan's Point Road
Lake Hopatcong, NJ 07849

From: _____ Child's/Children's Name: _____
Parent/Guardian Name
Address
City, State, Zip

Jefferson Child Care and Education Center is hereby authorized to automatically bill tuition payments from: a) my credit card account effective _____
b) my debit card account effective _____

This authorization can be terminated at any time by written notice to the Jefferson Child Care and Education Center. Payments will be for tuition. Automatic Payment to Jefferson Care Child Care Center:

- a) one month in advance
b) two weeks in advance (billed every two weeks)

Credit Card Type (MasterCard, Visa, Discover): _____

Debit Card Bank: _____

Name on Credit/Debit Card: _____

Billing Address: _____

Credit/Debit Card Number: _____

Expiration Date: _____

3-digit CVC Number: _____

Card Holder Signature

Date