ENROLLMENT AGREEMENT
THE TRAINING STATION NURSERY SCHOOL REGISTRATION

Class Assignment:_____ **Deposit Amount** _____ **Check#**_____ **Cash**_____

Hi Mama Invoice_____

CHILD'S NAME _____ AGE ____

DATE OF BIRTH _____ M F

MOTHER'S NAME _____ MOTHER'S CELL # _____

FATHER'S NAME _____ FATHER'S CELL # _____

MAILING ADDRESS _____

CITY, STATE, ZIP_____

EMAIL ADDRESS_____

LIABILITY STATEMENT

I know of no reason, health or otherwise, why _____ should be restricted from this program. I agree to hold the Training Station Nursery School, director and staff harmless for any accident.

Signature of parent or guardian: _____ Date: _____

PAYMENT AGREEMENT

I understand that my payment agreement is as follows:

1. REGISTRATION: An annual fee based upon the number of days attending is due and payable on the day of registration.

2. DEPOSIT: Upon registration you will pay a non-refundable deposit covering May's tuition (last month of the school year attending).

3. TUITION: Tuition is based on a yearly fee. You may choose to pay in monthly installments equal to 9 payments. September's payment is due upon entering school. Payment is due by the 1st of the month and late payments are subject to a $10.00 late fee per week that it is late.

**Tuition is not adjusted for vacation periods, inclement weather, absenteeism, emergency closures, and there are no makeup days in the schedule. Tuition payments are non-refundable.

4. METHODS OF PAYMENT: Payment may be made by check, money order, or credit card.
*Invoices will be generated through the **Hi Mama** app and payments may be made through the app.*

The Training Station will not be responsible for any payment lost, stolen or mislaid before delivery to the center.

5. REFUND POLICY: **All deposits are non-refundable.** Written notice of withdrawal must be received before **July 15th** of year enrolled. If notice is not received by July 15th, **September tuition will be due in full**.

I give permission for the school to use my child's photo for publicity purposes & for news items: Yes_____ No_____

I give permission for my address/phone number to be distributed to parents enrolled in this school: Yes_____No ____

I have been informed about A Parent's Guide To Regulated Child Care found at www.marylandpublicschools.org

I have read the payment agreement and hereby agree to accept the terms and conditions as stated above.

SIGNATURE OF PARENT OR GUARDIAN_____ DATE _____

Training Station Fees and Tuition 2020-2021

First Steps (All 2's classes)
(2 days per week)

monthly tuition $295

Total for year $2655

3's A.M.
(3 days per week)

monthly tuition $395

Total for year $3555

3's P.M.
(4 days per week)

monthly tuition $405

Total for year $3645

Pre-K
(5 days per week)

monthly tuition $445

Total for year $4005

Registration:

Fees due at registration include one month's tuition **PLUS** an annual fee determined by the number of days per week attending.

2 Days—$75

3 Days—$90

4 Days—$105

5 Days—$120

Policies Concerning Fees and Tuition

⇒ Families with 2 or more children enrolled enjoy a price break of $10 per child per month. This discount may not be used if you are paying in full prior to September 15th and receiving a 5% discount for early payment.

⇒ One month's non-refundable tuition plus an annual fee is collected with registration (applied to the last month of the school year). September's payment is due upon entering school in September.

⇒ Members of the clergy and families who regularly attend CrossWay Church receive a tuition reduction of 10% per child enrolled. Families who regularly attend CrossWay Church are given priority in regards to enrollment.

⇒ Tuition is not adjusted for vacation, inclement weather, absenteeism, or national or state emergency shutdowns and there are no make up days on the schedule.

⇒ Tuition is due by the 1st of each month and a $10 late charge is due each week that payment is late. Please note that we are always willing to work with you if you need to make payments on a different schedule than the one outlined. However, it is REQUIRED that you speak with the Director if you are unable to make payments as scheduled. Failure to make alternate payment arrangements with director could result in dismissal from the program.

⇒ Tuition will be invoiced through the **Hi Mama** app. You may also make payments through the app or make payments directly to the Training Station in the form of a check or cash. **Hi Mama** allows you the option to set up automatic payments, pay through a bank account, or pay by credit card.

⇒ There will be a $35 penalty fee for returned checks

⇒ Refund policy: **All deposits are non-refundable, no exceptions will be made**.

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes___ No___

Meals your child will receive while in care:

BK___ LN___ SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ (Last / First) Birth Date _____

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____ (Street/Apt. # / City / State / Zip Code)

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____ (Last / First / Relationship to Child)

Address _____ (Street/Apt. # / City / State / Zip Code)

Any Changes/Additional Information _____

ANNUAL UPDATES _____ *(Initials/Date)* _____ *(Initials/Date)* _____ *(Initials/Date)* _____ *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. # / City / State / Zip Code)

2. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. # / City / State / Zip Code)

3. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. # / City / State / Zip Code)

Child's Physician or Source of Health Care _____ Telephone _____

Address _____ (Street/Apt. # / City / State / Zip Code)

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ______________________________

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ______________________________

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

(2) If signs/symptoms appear, do this: ______________________________

(3) To prevent incidents: ______________________________

____

- -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________________

____

____

____

COMMENTS: ______________________________

____

____

____

____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ ______________________________
Name of Health Practitioner Date

______________________________ (_____)______________________
Signature of Health Practitioner Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations.*** *A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas.*** *The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/dhmh_4620_bloodleadtestingcertificate_2016.pdf

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/occ1216-medicationadministrationauthorization.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ Birth date: _____ Sex
Last First Middle Mo / Day / Yr M☐F☐

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	Name:	Physical Exam:
Address:	Address:	Dental Care:
Phone #	Phone	Any Specialist :

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poison/Exposure complete DHMH4620	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/maryland_immunization_certification_form_dhmh_896_-_february_2014.pdf

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature:_____ Date: _____

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:
(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results		Date Taken	
Tuberculin Test				
Blood Pressure				
Height				
Weight				
BMI %tile				
LeadTest Indicated:DHMH 4620 ☐ Yes ☐ No	Test #1	Test#2	Test # 1	Test #2

_____ **has had a complete physical examination and any concerns have been noted above.**

(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME_____/_____/_____
LAST FIRST MIDDLE

CHILD'S ADDRESS_____/_____/_____/_____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE____/____/____ PHONE_____

PARENT OR GUARDIAN_____/_____/_____
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print):_____**Signature:** _____ **Date:** _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name:_____ Signature:_____

Date:_____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print):_____Signature:_____Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name:_____ Signature:_____

Date:_____ Phone: _____

Office Address: _____

CENTER NAME: _____

Participation Agreement

to email and publish my child's work, photographs or videos via HiMama

To: Parent / Legal Guardian,

Please read this page carefully as it includes information about safety and security issues associated with privacy and behavior.

In the interest of safety and security we require parent permission for the publishing of children's work, photographs or videos through a software program called HiMama (the "**Program**"). By signing this form you grant permission for us to photograph or video your child for the purposes of sharing this information with you through the Program. You will also receive updates and information about your child through the Program to the email you have provided herein.

Note that sometimes other children in the center may feature in photos, videos or stories of your child. By giving your consent you agree not to share photos or video of any child, other than your own, outside the Program without permission.

To learn more about the Program, please visit www.himama.com. Please complete, sign, and return this form to the center if you wish to participate. We encourage you to contact us if you have any questions.

I hereby acknowledge that I wish to voluntarily participate in the Program:

My Child's Name: _____

My Name: _____

My Email: _____

Signature: _____ Date: _____

Note: Please complete the Participation Agreement for each parent / guardian of the child.