kangaroo's korner
Early Learning Center

Enrollment Packet Checklist

_____ **Application for Enrollment**

_____ **Emergency Contact List**

_____ **Prospective Enrollee Questions**

_____ **Child Development History of Enrollment**

_____ **Cultural Questionnaire**

_____ **Infant Individual Needs (if applicable)**

_____ **Care Plan***

_____ **Emergency Medical Care Form***

_____ **Physical & Immunizations***

_____ **Consent Forms**

_____ **Signed Parent Agreement Form**

_____ **Facebook Permission Form**

_____ **Copy of Birth Certificate***

_____ **Copy of Insurance Card***

********* All the items on the list with a star next to them we must have at the center before your child's start date. Your child will not be able to start until we have all the documents with a star next to them.**

kangaroo's korner
Early Learning Center

Enrollment Date: _____

Application for Enrollment

Child's Name _____ Birth Date _____ Sex ____ Race _____
Home Address _____ City, State, Zip _____
Home # (___)_____

Mother's Name _____ Birth Date _____ Cell # _____
Work # _____ Employer _____ Usual Working Hours _____
Work Address _____
E-mail _____

Father's Name _____ Birth Date _____ Cell # _____
Work # _____ Employer _____ Usual Working Hours _____
Work Address _____
E-mail _____

Names of Siblings that attend Kangaroo's Korner
_____

Are you applying for any Grants or Care 4 Kids? _____

Please check all sections that you will accept – Please number in order of preference:

Infant/Toddler: _____ F/T 50 hrs. _____ P/T 30 hrs. _____ P/T 20 hrs. _____ P/T 10 hrs.

	Mon	Tues	Wed	Thurs	Fri
Drop Off:	_____	_____	_____	_____	_____
Pick Up:	_____	_____	_____	_____	_____

Preschool/Half Day Kindergarten: _____ F/T 50 hrs. _____ P/T 30 hrs. _____ P/T 20 hrs. _____ P/T 10 hrs
(In day care setting)

	Mon	Tues	Wed	Thurs	Fri
Drop Off:	_____	_____	_____	_____	_____
Pick Up:	_____	_____	_____	_____	_____

Preschool Only Option: 3 & 4 Year Olds: Hours: 9:00 a.m. to 11:30 a.m.

_____Mon/Wed/Fri _____Tues/Thurs

Parent Signature: _____ ***Date:*** _____

For Office Use Only:
Administration Signature: _____
Registration Fee: $_____ Date PD: _____ Type of payment: _____
Security Deposit: $_____ Date PD: _____ Type of payment: _____

Catherine Risigo-Wickline OTR/L, *Founder/President*
120 French Mountain Road • Watertown, CT 06795 • 860-945-6628 • Fax 860-945-3151

kangaroo's korner
Early Learning Center

Emergency Contact Information

Primary (Mother & Father only) Emergency Contacts:

Name _____

Home Address _____

Home Phone _____

Work Phone _____

Cell Phone _____

Relationship to child MOTHER

Name _____

Home Address _____

Home Phone _____

Work Phone _____

Cell Phone _____

Relationship to child FATHER

Authorized persons to pick up your child (other than the parents):

Name _____ Home _____ Cell _____ Relationship _____

Name _____ Home _____ Cell _____ Relationship _____

Name _____ Home _____ Cell _____ Relationship _____

Name _____ Home _____ Cell _____ Relationship _____

Name _____ Home _____ Cell _____ Relationship _____

Name _____ Home _____ Cell _____ Relationship _____

Questions For A Prospective Enrollee

1. What are triggers for certain behaviors from your child? (for example: aggression, sadness, anger)

2. In what ways does your child exhibit these emotions? (for example: tears, chair throwing, hitting)

3. What techniques do you utilize at home when negative behaviors occur?

4. How does your child handle change?

5. What, if any, methods, does your child use to calm himself down?

6. What are the family dynamics like at home. (In other words, who takes care of the child besides...)

7. Are you open to assessments from our contracted therapists and behavior plans?

Kangaroo's Korner
Child Development History of Enrollment

Child's Name_____ Nicknames _____ Birth date _____

I. Sleeping

What time does your child go to bed? _____ Awaken _____
Does your child have its own bed? _____ Room _____
Does your child take naps? _____ From when ____ To when _____
What does your child take to bed/nap with them? _____
Do they take a pacifier or suck their thumb? _____

II. Eating Habits

What foods does your child especially like? _____
What foods do they dislike? _____
Is your child on a special diet? _____ Do they drink out of a bottle / open cup / or straw_____Does your child feed himself? _____ Where is your child fed while at home? _____

III. Social Relationships

Has your child participated in any group experiences? ____ Play Dates? ___
Does your child enjoy small or large play groups? ____How often? _____
By nature is your child (check one) Aggressive ____ Friendly ____ Shy ____ Other ____Does your child demand a lot of adult attention? _____
What upsets them? _____What frightens your child? _____
Favorite toys? _____What does your child most like to do for activities? _____

IV. Infants and Toddlers

Is your child's skin sensitive? _____ What is done for it? _____How is your child fed (check one) Held in Lap ____ Highchair _____ Other _____
Is your child toilet training? _____ Need reminding? ____
What is used at home (check one) Potty seat ___ Adult toilet___ Special toilet seat _____
If your child is a boy… does he sit or stand? _____Do they need help? ___
How frequently do accidents occur? _____

V. Additional Information

In what particular ways can we help you and your child in our center?
_____
_____
_____

Child Development History of Enrollment con't

VI. What are triggers for change in temperament for your child? (For example, what makes her angry, sad)?

VII. What techniques do you utilize at home when negative behaviors occur?

VIII. How does your child handle change?

IX. What type of methods does your child use to calm himself down?

X. What are the families dynamics like at home? (For example, who takes care of the child besides…)

XI. Are you open to assessments from our contracted therapists ad behavior plans?

Cultural Questionnaire

Our goal is to have cultural diversity permeate the daily life of the classrooms. We do this by exploring the simlitarities among people through their differences. Everyone laughs, cries, works, eats and plays. Yet, we all do these things in different ways. You can help us connect cultural activities to your child and family by completing this questionnaire. Your answers will also reflect your child's history.

1. Where was your child born?

2. Where was dad born?

3. Where was mom born?

4. Where were mom's parents born and where do they live?

5. Where were dads parents born and where do they live?

6. Did any grandparents or great-grandparents emigrate from another country?

7. What is your family's cultural/ethnic heritage?

8. What languages are spoken at home?

9. Does your family have any special customs or traditions? Would you be willing to share them with the class?

10. Do you have any special stories about a relative that is important to you family that you would be willing to share with the class?

11. Are there any special celebrations in your family?

Kangaroo's Korner Childcare Center
Infant Individual Needs

Child's Name_____ Date of Birth_____

Parent's Names_____

Nap Schedule:

How many naps during the day?_____ Length:_____

From_____ to_____

From_____ to_____

From_____ to_____

How does your child fall asleep at home?_____
(I.e. in swing, being rocked or simply placed in crib?)

Per State Regulations, all infants will be placed on their backs to sleep. However, if they are able to roll over onto their stomach themselves, they will be allowed to adopt whatever position they prefer to sleep.

Eating Routine:

Which does your child use? Cup Bottle Both

Formula: Amount_____
How often:_____
Burping Routine:_____

Breakfast: Foods:_____
Liquids:_____
Time:_____

Lunch: Foods:_____
Liquids:_____
Time:_____

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ Date of Birth ____/____/_____

Special health care need or disability:

Plan for appropriate care of the child in a medical or other emergency. An individual plan of care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the child care program.

Other relevant information:

Signature(s) of the Parent(s): Date Signed:

_____ ____/____/_____

_____ ____/____/_____

Note: Section 19a-79-5a(a)(2)(E) requires a child's Health Record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Section 19a-79-4a(h)(2)(H)(viii) requires that the health consultant shall assist in the review of individual care plans as needed.

Please use reverse side of this form for signature(s) of all staff responsible for the care of this child.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Community Based Regulation Section

EMERGENCY MEDICAL CARE
Family Day Care Licensing

Attention Provider: *This information must be kept current at all times. Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.*

Child's name:_____ Birthdate:_____

Parent's name:_____ Emergency Tel:_____

Parent's name:_____ Emergency Tel:_____

Address:_____ Town: _____ Zip Code:_____

Allergies:_____ Last Tetanus_____

Medical Facility:_____ Phone #:_____

Insurance Carrier and_____

Insurance ID:_____

Physician to be called in an emergency:

Name:_____ Phone #:_____

Address:_____ Town_____ Zip Code:_____

I give my consent for the day care provider named_____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____. I will be responsible for all medical charges.
(hospital or walk-in clinic)

X_____
Signature

_____
Printed Name

_____
Date

S:\Division\Licensure\Family\FieldForms\F_EmergMedCare.doc 3/16/12

Phone: (860) 509-8045, Fax: (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y N	Frequent ear infections	Y N	Asthma treatment	Y N
Allergies to food, bee stings, insects	Y N	Any speech issues	Y N	Seizure	Y N
Allergies to medication	Y N	Any problems with teeth	Y N	Diabetes	Y N
Any other allergies	Y N	Has your child had a dental		Any heart problems	Y N
Any daily/ongoing medications	Y N	examination in the last 6 months	Y N	Emergency room visits	Y N
Any problems with vision	Y N	Very high or low activity level	Y N	Any major illness or injury	Y N
Uses contacts or glasses	Y N	Weight concerns	Y N	Any operations/surgeries	Y N
Any hearing concerns	Y N	Problems breathing or coughing	Y N	Lead concerns/poisoning	Y N
Developmental — Any concern about your child's:				Sleeping concerns	Y N
1. Physical development	Y N	5. Ability to communicate needs	Y N	High blood pressure	Y N
2. Movement from one place to another	Y N	6. Interaction with others	Y N	Eating concerns	Y N
		7. Behavior	Y N	Toileting concerns	Y N
3. Social development	Y N	8. Ability to understand	Y N	Birth to 3 services	Y N
4. Emotional development	Y N	9. Ability to use their hands	Y N	Preschool Special Education	Y N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

ED 191 REV. 3/2015

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

***TB:** High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

***Result/Level:** ***Date**

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

***IMMUNIZATIONS** ❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
If yes, please provide a copy of an Asthma Action Plan
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II

Seizures ❑ No ❑ Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine						
Rotavirus						
MCV**						
Influenza						
Tdap/Td						

*Pneumococcal conjugate vaccine

**Meningococcal conjugate vaccine

Disease history for varicella (chickenpox) _____ (Date) (Confirmed by)

Exemption: **Religious** ____ **Medical: Permanent** ____ **†Temporary** ____ **Date** ____

†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

Consent Forms

Photo and Television Consent Form

_____ gives Kangaroo's Korner permission to take pictures of my child _____ in the childcare center or on any school field trips. We give permission for any television station or publication to video. We also give permission to interview or photograph my child, which would be seen on a television station or in the newspaper.

_____ _____

(Parent's Signature) (Date)

Permission slip for off premise outings

I, _____ give permission to Kangaroo's Korner to take my child _____ on outings off premise with an authorized staff member. "Off premise" constitutes any area surrounding the childcare center outside of the playground gates. (i.e. walks to the pond, the field, etc.).

_____ _____

(Parent's Signature) (Date)

Consent for evaluation

Since our mission is to service children of all abilities. I, _____ give permission to Kangaroo's Korner to evaluate my child _____ twice a year.

_____ _____

(Parent's Signature) (Date)

kangaroo's korner
Early Learning Center

120 French Mountain Road; Watertown Connecticut 06795
Lisa Osterberg Executive Director
860 -945- 6628 fax 860 -945- 3151

Dear Parents and Guardians,

As we continue our journey here at Kangaroo's Korner, we have decided to create our own Facebook page. There are many ways this will benefit our staff and parents/guardians. Our Facebook page will help notify our families about upcoming events, closings or delays, fun activities that are planned and any other important parent information or notices. The privacy setting will be kept so that **only** immediate families and current staff members will be accepted and able to see any pictures or posts that may be posted. By signing below, it will give Kangaroo's Korner permission to post pictures of your child on our Facebook page. (Pictures of children may stay up on the page for up to two years after leaving the Center, unless requested by the families otherwise.)

_____

(Parent/Guardian Signature)

Sincerely,

Ms. Melissa & Kangaroo's Korner staff

Parent Agreement Form

1. Tuition is due each and every week, regardless of your child's attendance. If your child is sick, if there is a holiday or you take a family vacation, regular tuition is still expected in a timely manner. Tuition may be paid any day of the week via cash, check or credit card.
2. If your child is pick up past their scheduled time there will be a late charge of $10.00 for every 15 minutes per child. If your child is here past 5:30pm, a late fee of $20 will be charged if you pick up between 5:38 and 5:45; $25 between 5:46 and 5:52; $30 between 5:53 and 6:00 and after 6:00 an additional $35 for every 10 minutes. This fee will automatically be added onto your bill.
3. Your child's medical forms must be current and updated on a yearly basis, including a copy of current vaccinations.
4. All tuition checks returned due to non-sufficient funds will automatically be assessed a $30.00 fee by Kangaroo's Korner.
5. A two week written notice is required if your child will no longer be attending Kangaroo's Korner. The security deposit, payed at the time of enrollment, will be applied to the last week's tuition fees. In case of a credit, a refund will be mailed within 30 days of your child's last day, after your child's account has been audited. If a two week notice is not submitted, the charge for a two week notice will be implemented.
6. All persons picking up your child from the Center must be listed on the proper forms in order for the staff to release your child to them. Please notify the Office of any changes. Any person picking up your child must be identified on the release form and will be asked to show identification.
7. All emergency phone numbers, emergency contacts, allergy information and medical information are to be current and updated. Please be sure to inform the Office of any changes in your child's health or family information.
8. Your child is to be checked in out each day on Procare by the adult dropping off and picking up. Children are not allowed to check themselves in or out, or touch the Procare machine. If an adult does not check the child in or out please notify the Office so we can do it. For the safety of your child, please let a staff member know when you arrive and depart.
9. Your child is not to be dropped off before the scheduled time. These types of changes affect staffing at the Center. Staff's schedules are based around children's schedules. If a change needs to be made with your child's schedule, a two week written notice must be turned into the Office, in order to allow for appropriate changes to be made with staff schedules. If an unforeseen problem does arise (traffic, accident, etc.), you need to notify the Center immediately.
10. Kangaroo's Korner does accept Care 4 Kids applications. However, full tuition is due by the parent each week until Care 4 Kids takes effect. Care 4 Kids will then reimburse the parents accordingly.
11. It is the responsibility of both the teachers and the parents to communicate and stay informed of your child's daily progress at the Center, and the activities that are going on throughout the year. This includes checking your child's mailbox and cubby each day reading the Parent Information Board located in your child's classroom.

We, the undersigned parents/guardians, understand the rules and regulations of Kangaroo's Korner, Inc. that are stated above. We understand that if we have any questions concerning the above polices or procedures, we should address them to the Administrative Office immediately. We also agree to abide by the following policies and procedures, and understand them clearly.

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Administration Signature) (Date)

Does your child have an allergy, asthma or a medical condition that needs special attention?

_____ Yes _____ No

If yes, please fill out the attached care plan. If your child has an allergy, we must have this filled out before your child starts at the center.

Thank you

We, the undersigned parents/guardians, have read and discussed with administration the policies and procedures of Kangaroo's Korner, Inc. We understand that if we have any questions concerning policies or procedures, we should address them to the Administrative Office immediately. We also agree to abide by the policies and procedures.

We acknowledge we have read through the following policies/procedures:

Parent Participation

Parent Responsibilities

Parent Rights

Tuition/Late Payments

Medication/Health/Sick Child

Accident Reports/Daily Sheets

Discipline

Diapering/Toileting

Inclement Weather/Closings

_____ Date_____

Parent/Guardian Signature

Mission Statement

We provide a diversified educational environment, which facilitates the development of self-esteem, and acceptance of self and others by learning through play, social interaction, along with an individualized curriculum for all children from six weeks to five years.

Educational Philosophy

Kangaroo's Korner educates and advocates on behalf of children of all abilities, teaching developmentally. Which include fostering appropriate educational applications and theories, fostering family values, good manners, a child's independence and a genuine respect for one another. Mastering these skills enhances a child's sense of self-esteem; this in turn will strengthen a child's academic performance.

Late Pick Up Policy:

Effective immediately, the following policies will be in place regarding picking up your child after their scheduled time.

- If your child is here past the time they are scheduled on a specific day, for every 15 minutes extra, a late fee of $ 15.00 per child will be charged.
- At 5:30, the following late fee will be implemented:
- 5:38 – 5:45: $20.00 per child
- 5:46 – 5:52: $ 25.00 per child
- 5:53 – 6:00 $30.00 per child
- After 6:00 $35.00 every ten minutes

At 5:37, if we have not heard from a parent, we will contact the parent first and then call emergency contacts if we have not gotten a hold of the parent.

The late fee will be automatically added to your bill.

If for any reason you feel that you will be late, please call the center to notify us as soon as possible.

KANGAROOS KORNER EARLY LEARNING CENTER

FEE SCHEDULE JANUARY 2023

A $50.00 non refundable registration fee and one weeks tuition as a security deposit will be charged at enrolment

INFANT/TODDLER		MONTHLY
5 DAYS PER WEEK	$295.00	$1,268.50
3 DAYS PER WEEK	$255.00	$1,096.50
2 DAYS PER WEEK	$225.00	$967.50

PRESCHOOL		MONTHLY
5 DAYS PER WEEK	$260.00	$1,118.00
3 DAYS PER WEEK	$210.00	$903.00
2 DAYS PER WEEK	$195.00	$838.50

MORNINGS ONLY PRESCHOOL (9:00 - 12:00)		MONTHLY
5 DAYS PER WEEK	$145.00	$623.50
3 DAYS PER WEEK	$120.00	$516.00
2 DAYS PER WEEK	$85.00	$365.50

PRE - K am. only follows the John Trumbull school calendar
If john Trumbull has no school there is no morning only Pre - K

* Credit/debit, checks, cash and money orders are accepted
* Payment may be made weekly, biweekly or monthly
* $30.00 fee for returned checks

LATE PICK UP FEE (after 5:30pm)

5:38 - 5:45pm $20.00 per child
5:46 - 5:52pm $25.00 per child
5:53 - 6:00pm $30.00 per child
After 6:00pm $35.00 every ten minutes

We must charge this amount to pay staff overtime. Late fees will be charged to your account.

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ **Date of Birth** ___/___/___

Special health care need or disability:

Plan for appropriate care of the child in a medical or other emergency. An individual plan of care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the child care program.

Other relevant information:

Signature(s) of the Parent(s): **Date Signed:**

_____ ___/___/___

_____ ___/___/___

Note: Section 19a-79-5a(a)(2)(E) requires a child's Health Record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Section 19a-79-4a(h)(2)(H)(viii) requires that the health consultant shall assist in the review of individual care plans as needed.

Please use reverse side of this form for signature(s) of all staff responsible for the care of this child.

What to Bring the First Day

- Lunch box with at least 3 snacks and a lunch (one for am snack, one for lunch, and one for pm snack). Please be sure that your child has enough to choose from but is not overwhelmed.

- Labeled water bottle. Labeled milk bottles (infants)

- A couple changes of clothes (this will be kept in your child's cubby at all times). Please be sure to check their clothes regularly for the seasons and sizes and change them out appropriately. They should have socks, pants, shirts, underwear, etc.

- Fitted sheet and blanket for nap/rest time and a pillow case to keep them in for sanitary reasons, with your child's name on them clearly (if you must bring a pillow, please keep it to a small child sized pillow and **not** a standard sized pillow)

- If your child is still in diapers please bring in a wipe container labeled with their name and a package of diapers

- If bringing diaper ointment, teething gel, or any other medication please be sure to fill out the appropriate forms and make sure everything is labeled with your child's name

Your child's teacher will let you know if diapers, wipes and changes of clothes are running low, for you to bring in more.

We request that children leave their toys from home at home, as the center is filled with lots of fun stuff to play with and do. However, if your child has a favorite buddy or book, he/she may bring it in for quiet time or circle time.

Everything should be labeled with your child's name.