marigold academy
Early Childhood Education

Summer Enrollment Form

Toddler and up

Child Information

Child's Name: _____ Enrollment Location: _____

Date of Birth or Due Date: _____ Sex: _____

Parent / Guardian Information

Parent / Guardian 1			
Full Legal Name:		Email:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		
Employer:		Job Title:	

Parent / Guardian 2			
Full Legal Name:		Email:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		
Employer:		Job Title:	

Parent / Guardian 3 (if applicable)			
Full Legal Name:		Email:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		
Employer:		Job Title:	

Describe the child's living arrangement and relationship with listed parents / guardians. *Example: Lives with Guardian #1 (mother) and Guardian #2 (stepfather) Mon–Wed; with Guardian #3 (father) Thur–Fri.*

Enrollment

Requested Start Date of Attendance (MM/DD/YY):	Year Starting Kindergarten:	Typical drop off & pick-up time(hours of attendance):

Enrollment Information

Part-time	Full-time	Monday	Tuesday	Wednesday	Thursday	Friday
☐ 2 days (select days) ☐ 3 Days (select days) ☐ 4 days (select days)	☐ Full-time (5 days)	☐	☐	☐	☐	☐

Every effort will be made to accommodate the requested schedule; however, specific days are not guaranteed. Enrollment is based on availability. If specific days were offered prior to enrollment, those will take precedence over any selections made on this form.

Are you interested in being on the waitlist for a different Marigold Academy location? ☐ Yes ☐ No

If yes, which location? _____

Emergency Contact Information

Please list at least two other individuals authorized for pick-up. These contacts will be used if parent/guardian(s) are unreachable in an emergency as well. **Do not list parent/guardian(s) already noted above.** Photo ID matching the name provided will be required at pick-up.

Emergency Contact 1

Full Legal Name:		Relationship to Child:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		

Emergency Contact 2

Full Legal Name:		Relationship to Child:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		

Emergency Contact 3

Full Legal Name:		Relationship to Child:	
Address:	City:	State:	Zip:
Cell Phone:	Other Phone (Work/Home):		

Health Information

Doctor's Name: _____ Practice Name: _____

Phone: _____ Address: _____

Dentist's Name: _____ Practice Name: _____

Phone: _____ Address: _____

Is the child covered by medical and/or hospital insurance? ☐ No ☐ Yes

Carrier: _____ Policy/Group #: _____

Policy Holder: _____

Please indicate any specific medical or health needs. ☐ No ☐ Yes - Provide details as applicable.

Does your child have any allergies including dietary? ☐No ☐Yes*: _____

Note: An Allergy & Emergency Plan is required.

Is the child currently taking any medication? □ No □ Yes – If yes, list medication*:

Note: A completed Medication Authorization Form is required for staff to administer any medication.

Child Profile

Please answer the following questions so we can learn more about your child and provide support and care based on your child's individual needs.

Please briefly describe your child's day from morning to bed time:
What activities or play experiences does the child enjoy most?
Are there any fears, dislikes, or sensitivities to be aware of?
How does the child typically respond to stress, frustration, or new situations?
What strategies are effective when offering comfort, guidance, or discipline?
Are there specific goals, skills, or behaviors to focus on while in care?

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Allergy & Anaphylaxis Emergency Care Plan

Child Name: _____D.O.B.:_____

Allergic to: _____

Weight: _____lbs. Asthma: ☐**Yes (higher risk for a severe reaction)** ☐**No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

PLACE PICTURE HERE

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following foods(s)**_____

_____

Even if the child has MILD symptoms after eating this food(s), Give Epinephrine immediately.

For **ANY** of the following **SEVERE** SYMPTOMS


Shortness of breath, wheezing, repetitive cough


Pale or blush skin, faintness, weak pulse, dizziness


Tight or hoarse throat, trouble breathing or swallowing


Significant swelling of the tongue or lips


Many gives over body, widespread redness


Repetitive vomiting, severe diarrhea


Feeling something bad is about to happen anxiety, confusion

OR A COMBINATION of symptoms from different body areas

1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing
- is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patients to ER, even if symptoms resolve. Patient shoulc remain inER for at least 4 hours because symptoms may return

MILD SYMPTOMS


Itchy or runny nose, sneezing


Itchy mouth


A few hives, mild itch


Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

_____

Epinephrine Dose: ☐ 0.1 mg IM

☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

_____

Other (e.g. inhaler-bronchodilator if wheezing):_____

_____ _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE **DATE**

_____ _____

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE **DATE**

Medication Authorization Form

Child's Full Name: _____ Date: _____

In the event of illness, injury, or accident requiring immediate medical attention while attending Marigold Academy, staff are authorized to administer basic first aid and act on behalf of the parent/guardian to seek emergency medical care. This includes arranging transportation to a medical facility and signing necessary medical release forms. Marigold Academy will make all reasonable efforts to contact the parent/guardian as soon as possible following any emergency. All costs related to medical treatment and transportation are the sole responsibility of the parent/guardian. Marigold Academy does not provide medical insurance coverage for enrolled children. Medical information on file may be shared with healthcare providers for treatment purposes. Authorization is granted for the release of the child's medical insurance information as needed for legitimate medical care.

☐ **I acknowledge and accept the terms stated above.**

It is the sole responsibility of the parent/guardian to provide any required medication or epi-pen for the child while attending Marigold Academy. Medications must be current, properly labeled, and submitted in accordance with the academy's medication policy. In the event that staff are required to administer medication or an epi-pen, Marigold Academy, its employees, and affiliates are released from any and all liability related to the use or administration of such medication.

☐ **I acknowledge and accept the terms stated above.**

Parent Siganture: _____ Date: _____

If prescribed medication:

Reason for Medication: _____

Prescription Name	Dosage	Time Administer	Refrigerate
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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Payment Authorization Form

Child's Full Name:_____Enrolled Center: _____

Parent/Guardian First & Last Name(s):_____

Parent/Guardian Phone Number(s):_____

Billing Address:_____City:_____Zip Code:_____

ACH Bank Information & Authorization			
Bank Account Holder*			
Bank Name		**Bank City & State**	
Account Number		**Routing Number**	
Account Type	☐ ***Checking***	☐ ***Savings***	
I authorize Marigold Academy to automatically process all amounts incurred once a month. I understand whether or not I am notified in advance, it is my responsibility to know when payments are due.			
Bank Account Holder Singature:			

*By signing below, I authorize my financial institution to debit my account for all amounts owed to Marigold Academy, including but not limited to tuition, deposits, late fees, late payment fees, late pick-up fees, returned payment fees, registration fees, and field trip fees. If a balance remains unpaid for more than 5 business days after the due date, a $50 nonrefundable late payment fee will be incurred and automatically processed. In the event of a returned payment due to insufficient funds, a closed account, or any other reason, I agree to pay a returned payment fee of $35 per occurrence, which may also be debited automatically. Debits will occur according to the payment schedule selected, and receipts will be provided on a quarterly basis. This authorization remains in effect until Marigold Academy receives written notification of my intent to terminate, allowing sufficient time to process the change. This payment authorization shall continue until any outstanding balance is paid in full or until an updated and verified payment method has been provided. Any modifications, including changes in payment frequency, account details, or center transfers, will require a new Payment Authorization Form, which must be submitted to the center's designated email address at least 10 business days prior to any changes. I agree to indemnify and hold Marigold Academy and my financial institution harmless from any damage, loss, or claims resulting from authorized transactions under this agreement. I understand I will not receive prior notification of each transaction. By signing below, I certify that I am the authorized user or account holder and will not dispute these debits, provided they align with the terms in the Parent Handbook, Parent Agreements, and this Payment Authorization Form.

_____ _____

Account Holder's Full Name (Print) Date

_____

Account Holder's Signature

Infant Feeding Plan

Infants ONLY

Child's Full Name:_____

DOB: _____ Date:_____

Formula:

☐ No ☐ Yes Is your child fed formula*?
☐ No ☐ Yes Will formula be prepared at home?
☐ No ☐ Yes Will formula be prepared by the caregiver?

If the caregiver will be preparing the formula, please indicate any special instructions:

_____

Breast Feeding/Breastmilk:

☐ No ☐ Yes Is your child breastfed?
☐ No ☐ Yes I will nurse my child at the center at these times:_____
☐ No ☐ Yes I will provide breast milk**.

If breast milk is unavailable for a feeding, the center should:

_____

Feedings:

☐ No ☐ Yes Does your child take a bottle? (Note: Bottles are required to be labeled with the child's name and current date.)
- ☐ No ☐ Yes Is the bottled warmed***?
- ☐ No ☐ Yes Does your child hold their bottle?
- ☐ No ☐ Yes Can the child feed his/herself?
- ☐ No ☐ Yes Are there any special instructions for bottle feeding your child?

If yes, please explain:

_____

☐ No ☐ Yes Is your child using a sippy cup? (Note: Sippy cups must be labeled with the child's full name.)
☐ No ☐ Yes Does your child have any problems with feeding, such as choking or spitting up?
If yes, please explain:

_____

What is your child's typical feeding schedule? _____

_____

☐ No ☐ Yes Are there any special instructions concerning feeding your child?
If yes, please explain:

_____

Feedings:

Liquids (formula, breast milk, 100% fruit juice)	Breast Feeding ☐ by bottle ☐ by breast	Bottle Feeding ☐ by caregiver ☐ with help ☐ independently	Cup Feeding ☐ with help ☐ independently	**Amounts:**
Semisolid Foods (infant cereal, strained fruits, and/or veggies)	☐ N/A ☐ Introducing ☐ Familiar	Spoon Feeding ☐ by caregiver ☐ with help ☐ independently	Kinds of Food:	**Amounts:**
Modified Table Foods (mashed, soft, diced fruit/veggies, strained meat or poultry, etc.)	☐ N/A ☐ Introducing ☐ Familiar	Spoon Feeding ☐ by caregiver ☐ with help ☐ independently	Kinds of Food:	**Amounts:**
Finger Foods (small pieces of soft/cooked table food, chopped food)	☐ N/A ☐ Introducing ☐ Familiar	Spoon Feeding ☐ by caregiver ☐ with help ☐ independently	Kinds of Food:	**Amounts:**

☐ No ☐ Yes Does your child take a pacifier? (Note: Pacifiers with straps/attachments are not permitted. Pacifiers must be removed when the child is crawling or walking.)

I will provide any updates to my child's feeding plan as needed.	**Parent's Signature:**	**Date:**

*Breast milk shall be gently mixed but not be shaken. Refrigerated breast milk shall be used within 24 hours. Formula or breast milk that is served, but not completely consumed or refrigerated, shall be discarded. **No milk, formula, or breast milk shall be warmed in a microwave oven.

Permissions

Promotional Release: From time to time Marigold Academy will share pictures and/or videos of students and classrooms to display activities, functions, events, and work performed by our staff on the school's social media accounts. Please fill out the form below indicating if you approve or disapprove of your child being featured on our social media accounts.

☐ **Yes**, I give my permission for my child's photography/video to be featured on the school's social media accounts. Please be assured that pictures will not have any child or staff member's name displayed to protect their identity.

☐ **No**, I do not give my permission for my child's photography/video to be featured on the school's social media accounts.

Child's Name:_____ Date:_____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature:_____

Applying Insect Repellent and/or Sunscreen:

As the parent/guardian of the above named child, I have initialed next to the applicable statement(s) for the use of insect repellent & sunscreen on my child:

_____ Staff may apply the parent-provided insect repellent according to the directions on the product label.

_____ **Please do not apply insect repellent to my child**

_____ Staff may use the parent-provided sunscreen according to the directions on the product label.

_____ **Please do not apply sunscreen to my child**

Additional Notes:

Center Name: _____ Date:_____

Child's Name:_____ Age: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature:_____

Permissions Cont.

Permission for Field Trips:

☐ **Yes**, I hereby give permission for my child to participate in field trips (walking or transported) that will be within the area or within 30 miles of the school. I understand that I will receive a permission slip per each field trip to acknowledge if my child is permitted to attend that specific field trip.

☐ **No**, I do not give permission for my child to participate in any field trips (walking nor transported).

Child's Name:_____ Date:_____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature:_____

Parent Handbook Agreements:

_____ I understand that Marigold Academy must receive legal documentation to enforce any custody arrangements or restrictions on child release. It is my responsibility to provide such documents and keep them up-to-date.

_____ I have disclosed all known allergies, dietary restrictions, or food-related health concerns. I understand it is my responsibility to update this information in writing to the school.

_____ I understand that Marigold Academy requires a 30 day written notice to withdraw through the withdrawal process form which I can obtain from my Center Director.

Center Name: _____ Date:_____

Child's Name:_____ Age: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature:_____

Marigold Academy reserves the right to change any policies if deemed in the interest of the school.

If, after reviewing the Parent Handbook, there are any questions regarding Marigold Academy's policies, parents/guardians should contact the Center Director.

I have read the Marigold Academy Parent Handbook and have been advised of all Marigold Academy's Policies and Procedures listed below:

- Welcome
- Registration Requirements
- Holiday Schedule & Emergency Closures
- Parent Notification Policy
- Tuition Policy
- Late Pickup Policy
- Statement Of Care
- Confidentiality Policy
- Social Media Policy
- Leave Work At Work Policy
- Student Requirements
- Student Files
- Parent Access
- Parking Policy
- Policy On The Release Of Children
- Voluntary Withdrawal Policy
- Involuntary Withdrawal/Expulsion Policy
- Positive Discipline Policy
- Health Policy
- Administration Of Medication
- Accidents & Injuries
- Biting Policy
- Meals & Snacks
- Food Allergies & Dietary Limitations
- Toys From Home
- Birthday Policy
- Outdoor Policy
- Evacuation Procedure
- Lockdown Procedures
- Additional Safety Procedures
- Final Word
- Information To Parents (DCF)
- Parent Handbook Acknowledgement of Receipt

Center Name: _____ Date: _____

Child's Name: _____ Age: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____