The Children's Village Early Learning Center
567 South County Trail
Exeter, RI 02822
Phone: 401-295-5240
Email: susan@thechildrensvillage.net

Registration Form

Child's Name _____

Child's Birth Date _____

Parent/Guardian's Name _____

Phone _____ **Email** _____

Address _____ **City/State** _____ **Zip**_____

Employer _____ **Phone** _____ **Email** _____

Parent/Guardian's Name _____

Phone _____ **Email** _____

Address _____ **City/State** _____ **Zip**_____

Employer_____ **Phone** _____ **Email** _____

Classroom (circle one): **Infant** **Toddler** **Preschool** **Pre-K**

Days (circle the days your child will attend):

Monday **Tuesday** **Wednesday** **Thursday** **Friday**

Drop-off Time:_____ **Pickup Time:**_____

Start Date _____

Child Care Assistance Number (if applicable):_____

A $35.00 registration fee and deposit of two-weeks tuition is due to secure placement.

PARENT AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I _____ (Parent or Guardian) hereby authorize The Children's Village to arrange medical examination and/or treatment of my child _____ (Child's name), should an emergency arise at the center. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided below, before any medical action is taken. I would prefer to have my child, if the need arises, taken to _____ hospital.

_____ _____ _____
Parent/Guardian Name Home/Cell Phone Work Phone

_____ _____ _____
Parent/Guardian Name Home/Cell Phone Work Phone

Emergency/authorized persons to pick up if you cannot be contacted in an emergency or sick situation.

Name _____ Phone_____Relation _____

Name _____ Phone_____Relation _____

Name _____ Phone_____Relation _____

_____
Medical Insurance Policy Number

_____
Policy Holder's Name

Allergies to food or medication _____

Consent for Release of Information

Child's Name:_____

Child's Date of Birth:_____

I authorize the following agencies to release information or records about my child to **The Children's Village** (please list all services involved with your child):

- **Pediatrician:**

  Name:_____ Phone Number:_____

- **Early Intervention:**

  Name:_____ Phone Number:_____

- **Department of Children, Youth and Families:**

  Name:_____ Phone Number:_____

- **School Department:**

  Name:_____ Phone Number:_____

- **Other:**

  Name:_____ Phone Number:_____

Medical information is protected under RI and Federal Laws and, except as provided by law, cannot be disclosed without written consent. Information released by this authorization will not be given, sold, transferred or relayed to any person or agency not specified above. This authorization is valid for 12 months from the date below, but may be withdrawn at any time by submitting a written revocation.

Signature: _____ **Date:**_____

Relationship to Child:_____

Tuition Deposit, Payment & Vacation Policy

Tuition Deposit

A two-week deposit is required to secure placement. One week will go towards the first week of enrollment and one week will be held until your last week of enrollment. Disenrollment of your child requires a two week written notice.

Payment Policy

Tuition payments for the following week will be due on the Thursday prior. You can pay weekly, bi-monthly or monthly. Parents who are paying by cash or check are required to leave payment in the morning during drop off time. Our tuition box is located in the foyer. For your convenience, we also accept ACH payments through our communication app, Brightwheel, with no fees. Credit cards are also accepted on Brightwheel. A **3%** processing fee will be applied to each transaction when using a credit card.

Please indicate which options you choose for tuition payments:

(circle one)	Weekly	Bi-Weekly	Monthly
(circle one)	Cash or Check	Bank Transfer (ACH)	Credit Card

Tuition is paid regardless of sickness, holidays, closing due to inclement weather and vacation time. A $25.00 late fee will be applied for late payments. A $35.00 fee will be applied for any returned checks.

Vacation

Children enrolled full time are eligible for 1-week vacation credit per year, based on their start date. You must be enrolled for 6 months before eligibility.

I have read and fully accept the terms listed in the payment policies for The Children's Village.

Parent/Guardian's Signature _____

Date _____

WAIVER OF LIABILITY

In consideration of the acceptance of this application, we/I

_____and _____
Parent/Guardian Parent/Guardian

waive our rights to commence any legal action or bring any claim against The Children's Village, Inc. in connection with any injuries sustained by my child. Upon acceptance of the registration fee and deposit, we/I understand that this agreement will be a binding contract enforceable by both parties.

Parent/Guardian's Signature _____

Parent/Guardian's Signature _____

Rhode Island Department of Human Services

All Providers: Photo Consent Form

Revised 1/2023

Photo Consent Form

I, _____, authorize, _____, to
Parent/Guardian's Name — Name of Center or Family Child Care

photograph or videotape my child, _____, related to any/all of the
Child's Name

following activities:

- ☐ To post in the classroom
- ☐ To post on the school's website or social media pages
- ☐ To post on the platform the school uses: _____

By signing below, I understand that the program may photograph my child during normal child care hours, field trips or activities. I also understand that this form is valid one (1) year from the date signed and it is my responsibility to update this form prior to this day if I no longer authorize the above consents.

_____ _____ _____
Parent/Guardian Signature — Parent/Guardian Name — Date

I, _____, **DO NOT** authorize, _____, to
Parent/Guardian's Name — Name of Center or Family Child Care

photograph or videotape my child, _____, related to any/all of the
Child's Name

following activities:

- ☐ To post in the classroom
- ☐ To post on the school's website or social media pages
- ☐ To post on the platform the school uses: _____

By signing below, I understand that the program **MAY NOT** photograph my child during normal child care hours, field trips or activities. I also understand that this form is valid one (1) year from the date signed and it is my responsibility to update this form prior to this day if I no longer authorize the above consents.

_____ _____ _____
Parent/Guardian Signature — Parent/Guardian Name — Date

This must be filled out by every parent and kept in the child's file.

Office of Child Care: 25 Howard Avenue, Building 57 | Cranston, RI 02920
Child Care Licensing Team: 401.462.3009 | DHS.ChildCareLicensing@dhs.ri.gov

School Name & Address:

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis TdaP/Td	Check ☐ if Td	Check ☐ if Td	Check ☐ if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: ☐ Medical ☐ Religious

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight _____ BP _____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No ☐ Yes ☐ **DIABETES: No ☐ Yes ☐** **OTHER:** _____

Significant Systems Findings: _____

ALLERGIES: No ☐ **Yes ☐ (Please explain)** _____ **EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐**

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No ☐ **Yes ☐ (Please list)** _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully☐ With limitation ☐ _____

Can participate in sports: Fully☐ With limitation ☐ _____

LEAD SCREENING (Required for children < 6 years of age only)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes ☐ No ☐	Yes ☐ No ☐	☐ Passed screening ☐ Screened and referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:		**Screening Date:** **Comprehensive Exam Date:**

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Revised 7-10

INFANT SOCIAL RESUME

Child's Name: _____ DOB:_____

FEEDING

Is your child breast-fed? ☐ Yes ☐ No
If yes,

Do you plan to continue breast feeding? ☐ Yes ☐ No
If yes, how do you plan to carry this out? _____
_____
Do you supplement? _____

Is your child bottle fed? ☐ Yes ☐ No
If yes, what is your child's bottle feeding schedule?

Liquids	Type	Amount	Times
Formula			
Milk			
Water			

What position does your child like to be in while bottle feeding? _____
_____
What position does your child like to be in while being burped? _____
_____

Has your child been introduced to solids? ☐ Yes ☐ No

If yes, what type? ☐ Baby food ☐ Table food
What is your child's feeding schedule?

Solids	**Type**	**Amount**	**Times**
Cereal			
Vegetable			
Vegetable			
Fruit			
Fruit			
Meat			

Does your child have any food sensitivities or allergies? ☐ Yes ☐ No
If yes, please identify: _____

Is your child under medical care for this allergy? ☐ Yes ☐ No
If yes, please submit an individualized care plan.

What foods does your child like or dislike? _____
_____

SLEEPING
Describe your child's sleep routine (include bedtime, naps & lengths of naps):

_____

_____

Where does your child typically sleep? _____

DIAPERING
What type of diapers does your child use?_____
What type of wipes does your child use? _____

Is your child prone to diaper rash? ☐ Yes ☐ No
Treatment: _____

SOCIAL/EMOTIONAL DEVELOPMENT
Describe your child's temperament: (i.e. colic, likes to cuddle)

_____

_____

What signs does your child give of being…
Hungry_____
Tired _____
Over Stimulated _____
Sick _____

Does your child separate easily from you? ☐ Yes ☐ No

Is your child afraid of anything? ☐ Yes ☐ No _____

Does your child have a favorite toy, blanket, or soother? ☐ Yes ☐ No

Does your child spend time with other children? ☐ Yes ☐ No

Please provide any other information relating to your child that would be helpful in understanding and caring for your child: _____

_____

_____

_____

Parent/Guardian Signature:_____ Date:_____