

Longview Metro Church
Mother's Day Out
Enrollment Information

At Longview Metro Church Mother's Day Out, we want to offer your child(ren) an experience of God's love through loving relationships and positive growth development. To seeing that each child is growing spiritually, mentally, physically, and socially, we will provide each child with positive stimulating learning activities and structured play time.

We will also introduce the basic concepts of our faith about Jesus Christ. Each day we will share Bible stories as a part of the child's learning experience.

No child will be refused enrollment based on race, religion, color, sex, national or ethnic origin. We will only refuse children with disabilities that prevent us from providing the kind of care they need.

- Schedule: Tuesday's and Thursday's 8:30 a.m. – 2:30 p.m.
- Supply Fee: \$40 per child per semester (August & January)
- Program Fee: \$13 per day per child (one day per week)
\$25 per week per child (two days per week)
- Items Needed: First day of class: sleeping mat, lunch box, Kleenex, wipes, crayons, pencils, glue, blunt scissors
- Lunch: Each child will need to bring a sack lunch. Food that needs to be heated in a microwave is permissible. Please no candy, gum, or sodas.
- Snacks: Morning and afternoon snacks will be provided by LMC Mother's Day Out. Please notify us of any food allergies.

Should you have additional questions that this or the Parent's Handbook does not address, please feel free to call us at (903) 757-2258

LONGVIEW METRO CHURCH
MOTHER'S DAY OUT
Enrollment Form

Child's Full Name _____

Nickname _____

Birth Date ____/____/____

Address _____

Home Phone Number _____

Circle Days To Attend: Tuesday Thursday

Father's Name _____

Employer/Address/Phone _____

Cell Phone _____ email _____

Work Hours _____

Mother's Name _____

Employer/Address/Phone _____

Cell Phone _____ email _____

Work Hours _____

Parent's Marital Status: Married Seperated Divorced Single Widowed

Child Lives With _____

If Divorced, Who Has Legal Custody _____

May the Non-Custodial Parent Pickup Child _____

The Child Will Be Released Only To Those People On This Form And The Following:

Name & Phone _____

Name & Phone _____

Emergency Contacts Other Than Parents:

Name & Phone_____

Name & Phone_____

Child's Physician/Phone_____

Child's Dentist/Phone_____

Any Allergies or Special Needs_____

Hospital Preference_____

Is Your Child Potty Trained_____

Does Your Child Need Help In: Dress/Undress Eating Washing Hands/Face

Does Your Child Have Any Special Fears_____

Has Your Child Been Away From Parents Before:

____Sitter ____Daycare ____Grandparents ____Other

Previous Childcare Provider/Name & Phone Number_____

Reason For Leaving_____

Favorite Game_____

Favorite Toy_____

Favorite Food/Snack_____

Food/Snack Your Child Doesn't Like_____

Any Additional Information_____

Health Record

Child's Name: _____ Sex: _____ Age: _____

Doctor's Name: _____ Phone #: _____

Doctor's Address: _____

Check Illnesses the child has had:

German Measles _____ Measles _____ Chicken Pox _____ Mumps _____ Scarlet Fever _____

Rheumatic Fever _____ Strep Throat _____ Allergies (Type): _____

Drug Reaction: _____

Medications: _____ Dosage: _____

Blood Type: _____

Is this child free from illness and communicable disease? _____

Is this child in good health? _____

Is this child's immunizations up to date? _____

Date of last immunizations:

DPT. _____ Measles _____ Tetanus _____ Booster _____ Polio _____ HIB _____

Chicken Pox Vaccine _____ TB Tine Test _____

Additional relevant information: _____

Is there any reason why this child should not be given non-prescription medicines by the child-care provider, with the parent's permission? i.e. aspirin, Tylenol, Pepto-Bismol, cough medicines, etc... Please note the exceptions which the child should NOT be given. State regulations states that " Prescription medications or aspirin shall not be given to a child except as authorized by a licensed physician and/or with a written daily request of the parent or guardian. Medication shall not be given to a child if the expiration date has passed."

(Parent/ Guardian Signature)

(Date)

Fee Agreement

Child's Name _____

A. LMC MDO charges **\$13.00 per day or \$25.00 per week** for all enrolled students ages 6 months – 5 years. All fees need to be paid weekly or monthly. Monthly fees must be paid on the first of every month. You must still pay for your child's scheduled time – regardless of whether or not the child is here. Those days and times are reserved for your child. The only exception is when taking a vacation. We ask that a two week written notice be given prior to taking vacation time.

B. Payments are due at the *beginning* of the business day each *Tuesday* for the current week's care. There will be a **\$5.00 a day late fee** for each week's payment that has not been received.

C. Other fees are as follows:

1. **REGISTRATION:** A non-refundable registration fee of \$40.00 will be due upon enrollment and each six months thereafter.
2. **RETURNED CHECKS:** A charge of \$30.00 will be assessed for any returned checks plus an additional late fee of \$5.00 per day until payment is made in full. Payments thereafter must be made by cash or money order.
3. **LATE PICK-UP FEES:** A \$5.00 late fee will be added to your account for the first 15 minutes you are late picking up your child. An additional \$2.50 will be charge for every five minutes you are late thereafter.

Should I/We decide to discontinue leaving our child in your care, I/We will give 2 week written notice.

(Signature of Parent or Guardian) (Date)

(Signature of Parent or Guardian) (Date)

(Signature of Provider) (Date)

Emergency Transportation and Treatment Authorization

Fill out either section 1 or 2 below. DO NOT fill out both.

1. Permission to Transport and Secure Treatment:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I grant my permission for:

(name of child care provider or facility)

to take my child: _____ (name of child)

to the nearest hospital or medical or dental facility for treatment for any accident or illness as deemed necessary by the provider. I accept liability for all treatment and ambulance expenses.

Signature of Parent or Guardian:

Date

2. Refusal to Grant Permission:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I **DO NOT** grant my permission for:

(Name of child care provider or facility)

to take my child: _____ (name of child)

to the nearest hospital or medical or dental facility for treatment for any accident or illness as deemed necessary by the provider.

Instead, I wish the following action to be taken:

Signature of Parent/Guardian

Date