



# GUIDING LIGHT

## Early Learning Center

### Guiding Light Early Learning Center

#### *Student Registration Checklist*

Welcome to Guiding Light Early Learning Center!! The following items must be delivered to the Executive Director before the first day of attendance.

- Immunization Form (your child's Doctor fills out this form)
- Physical Form/Health Care Summary (your child's Doctor fills out this form)
- Student Registration Form
- Multiple Permission Form
- Who Can/Cannot Pick-Up Your Child Form
- Emergency Contact Card (be sure to fill out both, with 2 emergency contacts that ARE NOT Mom or Dad)
- Registration Fee of \$45.00 (non-refundable)

# Child Care Immunization Form

*Must be on file **before** a child attends child care*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Date of Enrollment \_\_\_\_\_

Minnesota law requires children enrolled in child care to be immunized against certain diseases or file a legal medical or conscientious exemption.

**Parent/Guardian:**

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

Type of Vaccine	DO NOT USE (✓) or (✖)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
<b>Required</b> (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)						
<b>Diphtheria, Tetanus, and Pertussis (DTaP, DTP)</b> <ul style="list-style-type: none"> <li>• 3 doses during 1st year (<i>at 2-month intervals</i>)</li> <li>• 4<sup>th</sup> dose at 12-18 months</li> <li>• 5<sup>th</sup> dose at 4-6 years</li> </ul> <i>Indicate vaccine type: DTaP or DTP</i>						5th dose not required if 4th dose was given on or after the 4th birthday
<b>Polio (IPV, OPV)</b> <ul style="list-style-type: none"> <li>• 2 doses in the first year</li> <li>• 3<sup>rd</sup> dose by 18 months</li> <li>• 4<sup>th</sup> dose at 4-6 years</li> </ul>				4th dose not required if 3rd dose was given on or after the 4th birthday		
<b>Measles, Mumps, and Rubella (MMR)</b> <ul style="list-style-type: none"> <li>• Required for children 15 months and older</li> <li>• 1<sup>st</sup> dose on or after 1<sup>st</sup> birthday</li> <li>• 2<sup>nd</sup> dose at 4-6 years</li> </ul>						
<b>Haemophilus influenzae type b (Hib)</b> <ul style="list-style-type: none"> <li>• 2-3 doses in the first year</li> <li>• 1 dose required after 12 months or older</li> <li>• For unvaccinated children 15-59 months, 1 dose is required</li> <li>• Not required for children 5 years or older</li> </ul>						
<b>Varicella (chickenpox)</b> <ul style="list-style-type: none"> <li>• Required for children 15 months and older</li> <li>• 1<sup>st</sup> dose on or after 1<sup>st</sup> birthday</li> <li>• 2<sup>nd</sup> dose at 4-6 years</li> </ul>						
<b>Pneumococcal Conjugate Vaccine (PCV)</b> <ul style="list-style-type: none"> <li>• Required for children age 2 - 24 months</li> <li>• 3 doses in the first year</li> <li>• 4<sup>th</sup> dose after 12 months</li> <li>• At least 1 dose is recommended for children 24-59 months in child care</li> </ul>						
<b>Hepatitis B (hep B)</b> <ul style="list-style-type: none"> <li>• 2-3 doses in the first year</li> <li>• 3<sup>rd</sup> dose (final dose) by 18 months</li> </ul>						
<b>Hepatitis A (hep A)</b> <ul style="list-style-type: none"> <li>• 2 doses separated by 6 months for children 12 months and older</li> </ul>						
<b>Recommended</b>						
<b>Rotavirus</b> (2-3 doses between 2 and 6 months)						
<b>Influenza</b> (annually for children 6 months or older)						

**Instructions, please complete:**

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

<p><b>1. Certify Immunization Status.</b> Complete A or B to indicate child's immunization status.</p>	
<p><b>A. Children who are 15 months or older:</b></p> <p>For children who are 15 months or older and who have received all the immunizations required by law for child care:</p> <p>I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.</p> <p>_____</p> <p>Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic</p> <p>_____ Date</p>	<p><b>B. Children who are younger than 15 months:</b></p> <p>For children who are younger than 15 months OR have not received all required immunizations:</p> <p>I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:</p> <p>_____</p> <p>Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic</p> <p>_____ Date</p>

<p><b>2. Exemptions to Immunization Law.</b> Complete A and/or B to indicate type of exemption.</p>	
<p><b>A. Medical exemption:</b></p> <p>No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:</p> <p>I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):</p> <p>_____</p> <p>Signature of physician / nurse practitioner / physician assistant</p> <p>_____ Date</p> <p>*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)</p> <p>_____</p> <p>Signature of physician / nurse practitioner / physician assistant (If disease occurred before September 2010, a parent can sign.)</p>	<p><b>B. Conscientious exemption:</b></p> <p>No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:</p> <p>I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):</p> <p>_____</p> <p>Signature of parent or legal guardian</p> <p>_____ Date</p> <p>Subscribed and sworn to before me this:</p> <p>_____ day of _____ 20____</p> <p>_____</p> <p>Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)</p>

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

# Immunization Form

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

## Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

### Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
  - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
  - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
  - Document medical and/or non-medical exemptions in section 1.
  - Verify history of chickenpox (varicella) disease in section 2.
  - Provide consent to share immunization information (optional) in section 3.

**Instructions:** Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name \_\_\_\_\_

**1. Document a medical and/or non-medical exemption (A and/or B).**

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

**A. Medical exemption:** By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of health care practitioner\*)

**2. History of chickenpox (varicella) disease.** This child had chickenpox in the month and year \_\_\_\_\_

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of health care practitioner\*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

\*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

**B. Non-medical exemption:** A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I understand that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of parent or guardian in presence of notary)

**Non-medical exemptions must also be signed and stamped by a notary:**

This document was acknowledged before me on \_\_\_\_\_ (date) by \_\_\_\_\_ (name of parent or guardian)

Notary Signature: \_\_\_\_\_

Notary Stamp

STATE OF MINNESOTA, COUNTY OF \_\_\_\_\_

**3. Consent to share immunization information:** This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of parent/guardian)

# HEALTH CARE SUMMARY

**MUST BE COMPLETED BY HEALTH CARE SOURCE**

Date of Enrollment: \_\_\_\_\_

NAME OF CHILD \_\_\_\_\_

Birth Date \_\_\_\_\_

ADDRESS \_\_\_\_\_

Telephone \_\_\_\_\_

PARENT(S) OR GUARDIAN \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ How long have you been seeing this child? \_\_\_\_\_

How frequently do you see this child when he/she is not ill? \_\_\_\_\_

Does this child have any allergies (including allergies to medications)? \_\_\_\_\_

Is a modified diet necessary? \_\_\_\_\_

Is any condition present that might result in an emergency? \_\_\_\_\_

What is the status of the child's . . . Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

Please list below the important health problems

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program \_\_\_\_\_

Phone \_\_\_\_\_

**Signature of Health Source** \_\_\_\_\_ Address \_\_\_\_\_

**Date** \_\_\_\_\_



**Enrollment/Registration Form**

Student Information

Date of Birth: \_\_\_\_\_ Sex: **M F** Date of Application: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

First Middle Last Nickname

Child's Address: \_\_\_\_\_

No. Street City State Zip

Days And Hours of Care

\_\_\_ **Toddler** \_\_\_ **Preschool** \_\_\_ **School Age Care**

**Before School Only:** \_\_\_ **After School Only:** \_\_\_ **Before and After:** \_\_\_ **Summer:** \_\_\_

**Start Date:** \_\_\_\_\_

**Weekly Schedule: Drop off Time** \_\_\_\_\_ **M T W Th F** **Pick up Time** \_\_\_\_\_ **M T W Th F**

\*Staffing schedule is based off these hours. Guiding Light ELC maintains regular hours of operations Monday through Friday from 6:00 AM to 5:30 PM, please be as accurate as possible. Billing hours is based off of full time regardless of which days your child is in attendance.

Family Information

**Child Lives with:** \_\_\_\_\_

**Custody: Mother Father Both Other (specify):** \_\_\_\_\_

**Mother's**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Work Hours:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Best way to contact Parents:** \_\_\_\_\_

**Siblings and Ages:** \_\_\_\_\_

\_\_\_\_\_

**Father's**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Work Hours:** \_\_\_\_\_

**Email:** \_\_\_\_\_



Please list or describe your child's special interests, temperament, abilities, needs and personality you would like to share: \_\_\_\_\_

Has your child had any previous child care experiences? How was it?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any fears? : \_\_\_\_\_

Does your child have any Allergies, Medical, or Dietary requirements?  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any family traditions and/or customs you would like us to know about?  
\_\_\_\_\_  
\_\_\_\_\_

Is English your primary language? If no, do you need us to provide assistance in translating verbally or our written material?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have an Individual Child Care Program Plan (ICCPP) needs?  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like us to know about your child/family at this time?  
\_\_\_\_\_  
\_\_\_\_\_

Contacts

Your child(ren) will be released ONLY to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident, or emergency, if for some reason the custodial parent or legal guardian cannot be reached. **Guiding Light Early Learning Center must be provided with court issued custody papers that clearly describe the custody arrangements. Any person granted custody in such papers may pick up the child during the times that person has custody and may designate other persons who are authorized to pick up the child at such times, unless court papers state otherwise. This information will remain confidential and only shared with appropriate staff.**



Name	Phone	Alt. Phone	Address

Regular Medical Care	Regular Dental Care
<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address;</b>
<b>Phone Number:</b>	<b>Phone Number:</b>
Emergency Medical Care	Emergency Dental Care
<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address;</b>
<b>Phone Number:</b>	<b>Phone Number:</b>

A current health care summary and immunization record are required by Minnesota Rule 3 Child Care licensing before the first day of attendance.

Minnesota Rule 3 Child Care Licensing states that parents/guardians must receive a copy of the Parent Handbook and that the Program’s Child Care Program Plan be available to parents/guardians for review upon request.

Your signature below indicates that you have received and agree to the above items and that the information on this enrollment form is complete and accurate. By signing, you also agree that you have paid the \$45.00 non-refundable registration fee, met with the Executive Director, and you understand that your child will not be placed in the program at GLELC until the receipt/acknowledgement form of the Parent Handbook has been signed and returned to GLELC.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Executive Director)

\_\_\_\_\_  
(Date)



**GUIDING LIGHT**  
Early Learning Center

Guiding Light Early Learning Center

*Multiple Permission Slip*

Child's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

*By initialing the following items and signing below, you are agreeing to the following terms:*

\_\_\_\_\_ **Walking Trips:** I give permission to GLELC to take my child on supervised walking excursions.

\_\_\_\_\_ **Sunscreen:** I give permission to GLELC to apply sunscreen in the afternoon as necessary to protect my child from sunburn. I will put sunscreen on my child before drop off in the morning.

\_\_\_\_\_ I will provide my child's sunscreen (no aerosol cans) and will label his/her sunscreen with his/her first and last name along with which room he/she is attending.

\_\_\_\_\_ **Photographs:** I give permission to GLELC to take photographs of my child.

\_\_\_\_\_ **Facebook:** I give permission to GLELC to share pictures of my child on GLELC's Facebook page.

\_\_\_\_\_ **Website:** I give permission to GLELC to share pictures of my child on GLELC's website.

\_\_\_\_\_ **Printed advertising:** I give permission to GLELC to use pictures of my child for printed advertising without final proofing and/or receiving compensation.

\_\_\_\_\_ **Medical Emergency:** I authorize GLELC to take whatever medical measures are deemed necessary for the care and protection of my child. I understand that this may involve transporting my child to our doctor, hospital, or contacting 911 for assistance.

I understand, that by signing this form, I am giving permission to GLELC for the preceding terms that I have initialed.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(GLELC Executive Director Signature) (Date)



# GUIDING LIGHT Early Learning Center

## Guiding Light Early Learning Center

### *Pick Up Permission Form*

GLELC and the staff need to have a list of people authorized to remove your child from the center. Also, if there is someone who is **NOT** authorized, GLELC should know about it. If a carpool is used, please list the drivers involved.

Child's Name: \_\_\_\_\_

I authorize the following people to pick up my child and who cannot pick up my child:

<u>Who Can</u>		<u>Who CANNOT</u>	
(Name)	(Phone)	Name)	(Phone)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Enrollment Contract

I am (we are) enrolling my (our) children, \_\_\_\_\_ to Guiding Light Early Learning Center.

I (we) agree:

- To pay for the childcare services according to the fee schedule and to pay the tuition cost before the due date on the weekly invoice.
- That the late payment of my account will result in a late charge of \$5.00 per day beginning at 9:00 A.M. the day after the due date, until the balance is paid in full.
- Must notify the center by **8:30 AM** if their child will be absent due to illness, vacation, or another reason.
- Missing or incomplete forms may result in an assessment of \$20.00 which will be added to my tuition statement weekly until the information is completed.
- To pay an early arrival or late fee consisting of \$10.00 per child for every 5 minute period that I (we) arrive before or leave after Guiding Light’s opening (6:00AM) and closing (5:30PM) times. If staff cannot reach parents/guardians or emergency authorized pick-up people after 30 minutes past the closing time, Guiding Light ELC staff will be required to call the local Law Enforcement. The early/late fee **MUST** be paid directly to the staff member who was with your child before/after the centers opening/closing times.
- That my child may take part in field trips or excursions under proper supervision. I will sign my name to each field trip’s sign-up sheet in advance as consent for, each individual trip.
- That, in case of accident or injury, emergency medical care may be obtained by Guiding Light. I agree to pay for all medical and dental expenses incurred.
- To abide by the rules and policies of Guiding Light Early Learning Center as stated in the registration materials, newsletters, and other information.
- To give Guiding Light a 2-week written notice of cancellation of this contract and to pay the tuition for two weeks, whether in attendance or not.

I (we) acknowledge that I (we) have read, understand, and agree with the policies and procedures of Guiding Light Early Learning Center and are responsible for abiding by them.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**GUIDING LIGHT**  
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**Guiding Light Early Learning Center Contract**

**Child's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_

**All fees are based on a weekly schedule. Regular hours of operations are Monday through Friday from 6:00 AM to 5:30 PM.**

<b>Toddler (16 – 32 months)</b>	<b>\$255.00</b>	<b>Part-time Toddler</b>	<b>\$220.00</b>
<b>Preschool/PreK (33 mo. – summer before K)</b>	<b>\$235.00</b>	<b>Part-time Preschool/PreK</b>	<b>\$200.00</b>
<b>School Age (K – age 12)</b>			
<b>Just Before School or After</b>	<b>\$80.00</b>	<b>School Age – Summer Program*</b>	<b>\$201.00</b>
<b>Before &amp; After School</b>	<b>\$80.00</b>	<b>Part-time Summer Program</b>	<b>\$165.00</b>
<b>Non School/early out/late start per day (plus the weekly rate)</b>	<b>\$40.00</b>		
<b>Winter Break</b>	<b>\$201.00</b>	<b>Non-Refundable Registration Fee</b>	<b>\$45.00</b>

\*Field Trips and Activity Fees will be billed separately.

**By initialing the following items and signing below, you are agreeing to the following terms:**

\_\_\_\_\_ Weekly tuition is due and payable on the Friday preceding the week of service.

\_\_\_\_\_ All weeks require full pay, even if the child is not in attendance.

\_\_\_\_\_ Statements will be delivered via email at the beginning of the week and payments are due at the end of each Friday. Payments can be made by cash, checks, auto debit, and/or credit cards. If you are paying by cash or check, there is a payment box located outside the director's office. A charge of \$45.00 will be applied for NSF checks.

\_\_\_\_\_ A late fee will be charged for using GLELC outside of licensed hours (before 6:00 AM and after 5:30 PM). This fee will be \$10.00 per child, per 5 minute increment. If staff cannot reach parents/guardians or emergency authorized pick-up people after 30 minutes past the closing time, Guiding Light ELC staff will be required to call the local Law Enforcement. The early/late fee MUST be paid directly to the staff member who was with your child before/after the centers opening/closing times. Childcare may be discontinued here at GLELC if this continues to happen.

\_\_\_\_\_ I must give a written 2-weeks' notice, prior to the first day of the given month you wish to terminate your services with GLELC.

\_\_\_\_\_ I understand and agree to abide by the policies and procedures as stated in the Parent Handbook and this contract.

\_\_\_\_\_  
(Parent/Guardian Signature) (Date)

\_\_\_\_\_  
(GLELC Executive Director Signature) (Date)