Thank you for your interest in the Imagine Nation Early Learning Center. Attached is a registration packet to be filled out and returned to our office located at Imagine Nation, A Museum Early Learning Center, 1 Pleasant Street, lower level.

- Infant and Toddler families will pay an annual non-refundable $25 registration fee used for processing applications and a $50 deposit (applied to the last week’s tuition).

- We accept Care 4 Kids state assistance funding.

Please submit payment by check or money order (made payable to: INMELC) with your registration packet.

If you have any questions in regards to the registration procedure, please call 860-314-1400 or make an appointment for assistance.

Thank you.
PAYMENT POLICIES

- Tuition payments are due on Friday for the following week.

- Tuition payments must be made by check, money order, or automatic debit/credit card.

- In the event of a family crisis, please inform the Finance Department immediately.

- If any special payment arrangements need to be made, it is imperative that you contact the Finance Department to discuss and receive a written payment schedule.

- Weekly statements are available upon request.

- A 2-week written notice is required for withdrawal or for any changes in your tuition agreement.

- Yearly Tax Statements are available upon request (when all tuition has been paid).
FEES

REGISTRATION FEES

Mixed Age: $25 annually
(Infants & Toddlers)

Preschool: $25 annually

Both Mixed Age and Preschool Families must give a $50 deposit upon initial registration (applied to last week’s tuition).

*Please pay registration fee and deposit separately.

TUITION RATES

Mixed Age: $265 weekly

Preschool: SRG clients - based School Readiness Income Guidelines
Non-SRG clients - $195 weekly

LATE CHILD PICK-UP FEE

$20 per 15 minutes past 5 p.m. will be charged to child’s account.
REGISTRATION PACKET CHECK-OFF LIST

MIXED AGE PROGRAM:
$50 Registration fee
Registration Information sheets
Emergency Pickup other than parents
Signatures:  1. Parent/Guardian Agreement
               2. First Aid & Emergency Release
               3. Permission slip / Infant Sleeping Policy

Financial Disclosure Form
Care 4 Kids Application (Required to apply)
Care 4 Kids Check list
Automatic Credit Card Deduction Enrollment Sheet
Health Assessment Record
   Date of Physical: __________________
Asthma/Epi-Pen Orders and Individual Plan of Care
Registration Fee Check or Money Order # __________
Deposit Check or Money Order # __________________

Additional forms (not in Registration packet)

Care 4 Kids Application
Health Insurance Card (copy)
Copy of Parent(s) Driver licenses
Child Behavior Guidance Policy (Intake)
REGISTRATION & INFORMATION FORM

Registration Date: __________________________ E-mail address: ______________________________________

Child’s Name ___________________________________________ Home Phone__________________________

Child’s Resident Address ___________________________ City ______________________ Zip__________________

Child resides with (circle one):  Both Parents     Mother       Father       Other ________________________

Gender:   M  or F    Age ___________ Date of Birth ________________  Child’s Ethnicity_________________

Father’s Name _______________________________ Home Phone _______________ Cell Phone______________

Street Address _____________________________ City __________________ Zip__________________________

Employer________________________ Work Address __________________ Work Phone___________________

Mother’s Name _______________________________ Home Phone _______________ Cell Phone______________

Street Address _____________________________ City __________________ Zip__________________________

Employer________________________ Work Address __________________ Work phone___________________

Marital Status of Parents (circle one):   Single             Married            Divorced            Separated

I, ______________________________________ ____________________________ (Parent Signature) give the following people permission to remove my child from this Center.

NAMES OF ADDITIONAL AUTHORIZED PEOPLE WHO MAY REMOVE MY CHILD FROM THE PROGRAM AND ALSO BE CONTACTED IN CASE OF EMERGENCY, WHEN A PARENT CAN NOT BE REACHED:

NAME_________________________RELATIONSHIP_________________PHONE________________________

NAME_________________________RELATIONSHIP_________________PHONE________________________

NAME_________________________RELATIONSHIP_________________PHONE________________________

(WE PROVIDE A FULL TIME PROGRAM ONLY, MONDAY – FRIDAY)

Arrival Time: __________________________  Departure Time: __________________________

Starting Date: _________________________  Registration Fee Paid: __________________________

5
CHILD’S NAME __________________________________________

PERSONAL HISTORY
How did you find out about our Early Learning Center? ______________________________________________
Is child now or has been enrolled in any type of special education or interest program? YES or NO
Where: ________________________________________________________________
How would you rate your child in relation to his/her school experience?
Successful _________ Troubled__________ Difficult ____________ Enjoyable_____________

HEALTH
Child’s Physician _______________________________ Phone: ________________________________
Child’s Dentist _____________________________ Phone: ________________________________
Any medications given regularly? _______________ If so, what? _____________________________
Are there foods your child can not eat? _______________ If so, what ___________________________
Any allergies? _______________ If so, what _____________________________
Does your child use an EpiPen? _______________
What arrangements can you make for your child’s care during illness? __________________________
What communicable diseases has your child had? Measles _________ Mumps__________ Chicken Pox____
Other___________________________________________________________________________
Any serious illnesses/hospitalization?_____________________________________________________________________
Any physical disabilities?_____________________________________________________________________

PARENT/GUARDIAN AGREEMENT

I approve this application and certify that the proposed participant is capable of such an experience. I authorize the Imagine Nation Early Learning Center to have and use photographs, slides, moving pictures, or television videotapes of the person(s) named on this application for appearance in newspapers, magazines, brochures, websites, social media, or other publicity or media outlets. (Your permission for photos and videos including your child to be used without compensation is part of this agreement.) I also give permission for photographs and/or videos to be used as an assessment or learning tool, classroom display, and portfolios.

_________________________________________   __________________________
Parent/Guardian Agreement                        Date
FIRST AID AND EMERGENCY RELEASE FORM

I / We grant permission for the staff to take whatever steps necessary to obtain emergency medical aid if warranted for my child. These steps may include but are not limited to the following:

1. Administer First aid
2. Attempt to contact a parent / guardian
3. Attempt to contact child’s physician
4. Attempt to contact the parent through any people listed as emergency contacts
5. If we cannot contact the parents of the child or the physician, we may do any or all of the following:
   * Call another physician
   * Call an ambulance
   * Have the child taken to an emergency hospital in the company of a staff person.

Choice of Hospital____________________________________

Family Doctor _________________ Phone # ________________________________

Insurance Information: ID # _______________ Type of Insurance: _______________

Insurance holder’s name: ________________________________________________

I understand that the Imagine Nation Early Learning Center will not be responsible for anything that may happen as a result of false information given at the time of enrollment. It is the parent’s responsibility for keeping information up to date I understand that any expenses incurred will be borne by the child’s family.

__________________________________________ ______________________________
Parent’s signature Date
PERMISSION SLIP

I, ________________________ give the staff of the Imagine Nation Early Learning Center permission to apply sun block lotion to my child __________________________. I understand I am responsible for bringing in a labeled bottle that does not contain an antibiotic or prescription lotion.

I ,______________________ give my child __________________________ permission to ride in the baby buggies/strollers with the staff at the Imagine Nation Early Learning Center on the facility property and on the sidewalks of Upson St., Pleasant St., Church St., West St., North Main St., and Laurel St.

I, _________________ give my child __________________________ permission to participate in activities and licensed and unlicensed areas (i.e. museum studios) of at the Imagine Nation Early Learning Center. I understand my child will be under the supervision of the Imagine Nation Early Learning Center staff.

I, _____________________ give my child __________________________ permission to play on the playscapes located on the facility grounds of all our centers.

____________________________________  _______________________
Parent Signature                      Date

INFANT SLEEPING POLICY

Providing your infant with a safe environment in which to grow and learn is of extreme importance to us. To that end, our care facility has implemented policies and procedures to create a safe sleep environment for your infant. We follow the recommendations of the American Academy of Pediatrics (AAP) and the Consumer Safety Commission for safe sleep environments to reduce the risk of sudden infant death syndrome (SIDS). SIDS is “the sudden death of an infant under 1 year of age, which remains unexplained after a thorough case investigation.”

Our written policy is as follows:

- All infants under 12 months will be placed on their backs in safety-approved cribs unless an alternate sleep position is needed for medical reason and written note from the infant’s health professional is provided.
- When infants can easily turn over from the back position, they shall be put down to sleep on their back, but allowed to adopt whatever position they prefer to sleep.
- No blankets are allowed in cribs for infants less than 12 months of age.
- Infants will not sleep on water beds, sofas, soft mattresses, or other soft surfaces.
- Soft materials such as pillows, quilts, comforters, sheepskins, stuffed toys, and loose bedding will not be placed in infants’ sleep environment.
- Infants will remain lightly clothed and comfortable while sleeping.
- Supervised “tummy time” will be observed while infant is awake.

Since the start of the 1994 national campaign that provided guidelines to parents, health professional, and other caregivers to place infants on their backs to sleep, the number of infants dying of SIDS has decreased by 42%. Again, safety of your infant is paramount to us. By signing below, you, as a parent, understand and comply with the policies of the INMELC program.

____________________________________  _______________________
Signature of parent/guardian                      Date
Financial Disclosure Form (Finance Office Copy only)
School Year 08/31/20 to 8/20/2021

Child’s Last Name: ______________________________________ First Name_____________________________________

Child’s Date of Birth: ____________________________________________________________

Responsible Payee: ____________________________________________________________

Payee’s Address: _______________________________________________________________

Home #:_____________ Work #:_______________ Cell #:___________________________

Circle one:

- Mixed Age Group
- Preschool (Infant & Toddler)

Authorized Persons who may discuss this account and their relationship to Responsible Payee:

Name__________________________________________________________
Relationship____________________________________________________

Name__________________________________________________________
Relationship____________________________________________________

Name__________________________________________________________
Relationship____________________________________________________

Name__________________________________________________________
Relationship____________________________________________________

Responsible Payee Signature
__________________________________________________________ Date____________________
Care 4 Kids Check List

New Applicants (Please fill out the following form & return with C4K paperwork)

Circle one:  Mixed Age          Preschool
            (Infants & Toddlers)

_________________________      _______________________
Child’s Name                  Applicant Name

Child’s date of birth: _________

Hours in program:  From: ______a.m.  To: ______p.m.

Weekly Fee: ________

Start Date: _________

Application Form

Pay-Stubs (4 wkly – 2 bi-wkly)

Proof of Address

Copy of License

Parent Provider Agreement Form (PPA-signed by parent)

Child’s date of birth: _________

Hours in program:  From: ______a.m.  To: ______p.m.

Weekly Fee: ________

Start Date: _________

*** If the parent has an active certificate and is switching Providers, please have the parent fill out a new PPA form***
CREDIT / DEBIT CARD DEDUCTIONS

AUTOMATIC CREDIT / DEBIT CARD DEDUCTIONS

Client’s Name: ___________________________  Child’s Name: ___________________________

Client’s Address: __________________________________________________________________________

Client’s Email: __________________________________________________________________________

“I authorize The Imagine Nation Early Learning Center to make a single charge or automatic deductions from my Credit / Debit card for payments. “

Automatic charges (Automatic charges are for the weekly tuition or monthly tuition.) are as follows (check 1):

☐ Monthly (last Friday of the month prior to the month of service. The monthly tuition may encompass 4 or 5 weeks of tuition)

or,

☐ Weekly (each Friday, prior to the week of service ), or

☐ As a one time charge in the amount of $________. Reason: ______________________________

Credit/Debit card info: (please check)  ☐ MasterCard  ☐ Visa

Card holders name (as it appears on the credit/debit card)

____________________________________________________________

Credit/Debit card number:

____________________________________________________________

Credit/Debit card date of expiration:

____________________________________________________________

Security Number (back of card – last three/four numbers):

____________________________________________________________

Billing address:

# & Street Address

____________________________________________________________

Zip code

State

City

Phone Number

Card holder’s signature ___________________________  Date ___________________________

Please note: If your credit/debit card is declined 3 times, you will be required to pay your child’s tuition ASAP by money order. Card payments are run on Fridays (prior to the week/month of service excluding holidays and will be processed on the next business day). Your bank may not post it to your account until a later date, so please make sure your funds are available as we are not responsible for bank fees and overdraft fees.

This Authorization form expires 8/20/2021

PLEASE RETURN IN SEALED ENVELOPE TO:  ECE FINANCE OFFICE, 1 PLEASANT ST, BRISTOL, CT 06010