CHRIST LUTHERAN
EARLY CHILDHOOD CENTER

2020

REGISTRATION PACKET

MANDATORY FORMS:
***2020 Emergency Contact Information**
***2020 Student Contract**
***Photography Form**
***Drop Off/ Pick Up (make any necessary changes)**
***Physical & Immunizations (Please make sure we have the most recent)**

Hours of Operation:
Monday-Friday
6:30 a.m.-6:00 p.m.
*Pandemic hours 7:15am-5:00pm

330 Church St., Amston, CT 06231 860-228-5134 Fax: 860-228-1062
www.clecchebron.org, admin@clecchebron.org

For Your Reference:

☎ Classroom Phone Extensions – If you call CLECC and get the voicemail, any time during the message dial the corresponding extension to be connected:

Front Desk: 300
Pastor: 301
CLECC Director: 302
Business Manager: 303
Fellowship Hall: 304
Infants: 305
Waddlers: 306
Toddlers: 307
Pre-3: 308
Pre-K: 309
Room 6: 310
Front Door Intercom: 333

Email Directory:

Administration:

Laura Kraft: Director

Director@clecchebron.org

Pastor Booe: pastor@clchebron.org

Church Secretary: admin@clchebron.org

Christ Lutheran Early Childhood

Student Enrollment Form

Student Name (Last, First) ______________________ **Student DOB** __________

Parent Name (Last, First) ______________________

Address (Street, City, State, Zip) ______________________

Email ______________________ **Phone Number** ______________________

Were you referred by a CLECC family? Family Name: ______________________

Program Selection

Please select the program you are interested in enrolling your child in based on the age your child will be at the time of attendance. Please note that a minimum of two days is required for enrollment in any program. Please circle the days of the week that you are interested in having your child enrolled.

Program	Days	Anticipated Start Date*
❒Infant Program (6 weeks – 12 mos.)	M T W TH F	
❒Waddler Program (1 year - 2 yrs.)	M T W TH F	
❒Toddler Program (2 yrs. – 3 yrs.)	M T W TH F	
❒All Day Preschool (3 yrs)	M T W TH F	
❒Preschool Plus (4 – 5 yrs)*	M T W TH F	9:00-12:30
❒All Day Pre-Kindergarten Program (4 yrs.- 5 yrs.)	M T W TH F	
❒ Before School Care	M T W TH F	
❒ After School Care	M T W TH F	
❒Before & After School Care	M T W TH F	

*The $95 registration fee applies to the anticipated start date noted above. If, once that start date has been reached, you need to adjust the start date an additional $95 registration fee will be required. This registration fee will be required for every 30 days that the start date is pushed back.

†If you are registering your infant before they are born, please call within 30 days of their birth to confirm the start date.

Reminders and Notices:

Parking: You must park **in a parking space** in the parking lot**.** Parents may not park in the Fire Lane. You must enter and exit through the main doors in the Lobby or the connector door. The exits on the parking lot side of the building are Emergency Exits only. Children should not be left unattended in cars especially in warm weather.

Playground Access: If your child is under 3 you may access the playground through their classroom. If your child is over 3 you must access the playground by using the door at the end of the hall.

Drop Off and Pick Up: CLECC assumes responsibility for children from the time that they are checked into Brightwheels till the time they are checked out. Please escort your child to their classroom and verify with their teacher they are checked in. Pandemic drop off: Parents will be given staggered arrival times as close to their requested drop off times as possible. Please be respectful of our social distancing efforts when arriving and wait outside or in your car until the foyer is clear for your entry. When picking up your child message on Brightwheels 10 minutes before your arrival. Children under three will be picked up in the foyer and over three from their classrooms side doors.

Physicals: Are due annually Per Ct statute:19a-79-5a: a health record that shall include, but not necessarily be limited to: a physical examination form signed by a physician, physician assistant or advanced practiced registered nurse documenting an examination completed within one (1) year prior to enrollment, and yearly from the date of the initial physical examination thereafter, with a thirty-day allowance, which form shall provide:

A statement about the child's general health and the presence of any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affect this child's functional ability to participate safely in a daycare setting.

Flu Shots: As per the State of Connecticut of Public Health: Children aged 6-59 months attending a child daycare center, group daycare home, or family daycare shall receive at least one dose of influenza vaccine between

September 1 and December 31 of the preceding year. If children are vaccinated during August with the upcoming seasonal flu vaccine, these vaccinations will be accepted and count toward the mandated requirement. All children aged 6-59 months who have not received vaccination against influenza previously shall receive 2 doses of vaccine the first influenza season that they are vaccinated. Children enrolling between January 1 and March 31 shall receive influenza vaccine prior to daycare entry. Children enrolling after March 31 during any given year are not mandated to meet influenza vaccine requirement until the following January, as the influenza season has generally passed by this date and vaccine is no longer available.

Key Fobs/Entry: Each family is issued 2 per family (unless otherwise specified). Key fobs are $10 each and this fee is returned to you when fobs are returned to CLECC. You can have as many key fobs per family as you need. Replacement key fobs are $25 each and this fee is non- refundable. If when you do not have a key fob, ring the doorbell and wait for an answer. Speak loudly and clearly. State who you are and why you are here. When you send someone to pick up your child that does not normally do so, they will be asked to verify that they are approved to transport your child.

Tuition Payments: Weekly tuition is due Monday of each week. If payment is not received by Wednesday 10 a.m. a late fee of $25. will be added. No child will be allowed to attend the program if payments are left unpaid or excessive late payments.

Tuition payments and billing is on your child's account on Brightwheels. Online payments can be done through their billing program.

Pandemic Hours Of Operation:

7:15a.m-5: 00p.m

Christ Lutheran
Early Childhood Center

Children Infants to under 3 Years

Full Time (4-5 days/week) $280.
Part Time (2-3 days/week) $70.

Preschool/Pre-K

Full Time (4-5 days/week) $247

Part Time (2-3 days/week) $63/day

Preschool Plus

Available for the Pre-K Classroom

Full time (5 days a week) 9-12:30 = $125. Wkl

Monday, Wednesday & Friday 9:00-12:30

$90. wkly

*****All tuition fees are based on 10 hours per day. An extra $10. per hour for each additional hour.***

School Age Childcare

Before & After School

$130 weekly for both AM and PM care. This includes any delays and early dismissals.

Before School*

$ 50.

After School*

$ 80.

** Additional pricing for public school vacations, holidays, and snow days*

Before School only student- $35/day

After School only student- $30/day

Before and After School- $25/day

Fees and Discounts	
Security Deposit: This is a non-refundable fee due upon Enrollment. This is to be used for the last week that your child is at CLECC provided we are given a TWO WRITTEN NOTICE that your child is leaving the program. If paid in advance and then decide not to attend, this deposit will NOT be refunded.	Equal to 1 week's tuition. If a part-time parent chooses to go to full-time hours The security deposit must increase accordingly.
Registration fee: Non-refundable fee which secures enrollment. Due upon enrollment.	$95/Per child
Re-registration Fee: Annual non-refundable fee that covers the cost of updating student files per state regulations. Due September 1rst annually.	$75/child
Re-registration Fee for School Year Students: Students that un-enroll for the summer are required to pay a Registration Fee upon re-enrollment.	Per $95
Key Tags: Fee paid upon enrollment for keyless entry. This fee is refunded when the tags are returned to CLECC	$10 per tag (unless otherwise specified, 2 tags are issued per family)
Replacement Key Tags: This fee in non-refundable	$25 per tag
Extra hours fee- Full time tuition is based on a maximum Of 10 hours per day. Anytime over is $10 per hour.	$10 per hour
Late Pick-Up Fee: Fee for the Pick-up of a child after 6:00 PM / or 12:30 p.m. for Preschool Plus	$25 for each 15 minutes. Fee is per child.
Late Tuition Payments: Payments made after 10 a.m. on Wednesday for accounts with a balance due.	$25 per weekly billing cycle
Returned Checks: A fee is charged for checks returned by the bank due to insufficient funds.	$25
Multiple Child Discount: For families with more than one child enrolled Full Time in Infants, Waddlers, Toddlers, Pre-3, Pre-K or Before and After School Care. Discount is applied to the lowest contracted tuition price. May not be combined with other discounts or applied to Camp or Drop In.	10% off additional children.
Church Discount: Must be an active, attending member Of Christ Lutheran Church. The Elders of the Church determine if eligibility for the discount has been met.	15% percent per family

Christ Lutheran Early Childhood Center
STUDENT EMERGENCY INFORMATION FORM

Student Last Name:	Student First Name:
Student DOB:	Address, City, State & Zip:

SECTION I

Charge Parent of Record Information

Charge parents of record are those parents of a CLECC student who are legally responsible for the enrolled child as well as for all decisions to be made with regard to the child in connection with their attendance at CLECC. In most cases both parents share this responsibility and identify two charge parents of record so that both have the ability to provide special instructions concerning their enrolled child; however, you may choose to identify only one charge parent of record. If only one parent is identified as the charge parent of record, only that parent shall be authorized to complete or modify the information required by this form, or to provide special instructions related to the care of the enrolled child.

Charge Parent of Record (1)	Other Parent (2) Please circle if this parent is to be recognized as an additional Charge Parent of Record Yes No
Name:	Name:
Relationship to Child:	Relationship to Child:
Home Phone: (if none, leave blank)	Home Phone: (if none, leave blank)
Work Phone:	Work Phone:
Name of Employer:	Name of Employer:
Work Address:	Work Address:
Cell Phone:	Cell Phone:
Email Address:	Email Address:

SECTION II

Additional Emergency Contacts

In the event that the charge parent(s) of record listed above cannot be reached in the case of an emergency, the contacts listed below will be contacted in the order listed.

Contact # 1:	Relationship to Child:
Home Phone:	Home Address:
Work Phone:	Employer:
Cell Phone:	Work Address:
Contact # 2:	Relationship to Child:
Home Phone:	Home Address:
Work Phone:	Employer:
Cell Phone:	Work Address:

SECTION III

Medical Information

Known Allergies:	Suspected Allergies:
Chronic Illness:	Known Drug Intolerances:
Medications Child is Taking:	Medical Conditions of Child:
Insurance Carrier:	
Group Number:	Policy Number:
Child's Primary Physician:	
Office Address	Phone Number
Child's Dentist:	
Office Address:	Phone Number:

In case of a medical emergency, I give permission for my child to be transported by ambulance to a local hospital.

☐ Yes ☐ No

Hospital Preference: ____________________

In the event of an emergency, I give the staff of CLECC permission to follow the Emergency Medical Procedures (posted on the bulletin board in CLECC lobby) for my child. *Initial*

Special Instructions:

____

____

____

I understand that the information required by this form is utilized by CLECC as the primary emergency related information for my child, and that as such it is my responsibility to routinely update the information required on this form as it changes.

Charge Parent of Record: ____________________

(Please Print)

Signature: ____________________ Date: ____________________

Christ Lutheran Early Childhood Center

STUDENT DROP-OFF/PICK-UP AUTHORIZATION FORM

Please update this form as often as necessary. We will not release your child to someone not listed below.

Student Last Name:	Student First Name:
Student DOB:	Classroom Assignment:

SECTION I

Charge Parent of Record Information

Charge parents of record are those parents of a CLECC student who are legally responsible for the enrolled child as well as for all decisions to be made regarding the child in connection with their attendance at CLECC. In most cases both parents share this responsibility and identify two charge parents of record so that both have the ability to provide special instructions concerning their enrolled child; however, you may choose to identify only one charge parent of record. If only one parent is identified as the charge parent of record, only that parent shall be authorized to complete or modify the information required by this form, or to provide instructions related to exceptions.

Charge Parent of Record (1)	Other Parent (2) Please circle if this parent is to be recognized as an additional Charge Parent of Record Yes No
Name:	Name:
Relationship to Child:	Relationship to Child:
Home Phone: (if none, leave blank)	Home Phone: (if none, leave blank)
Name of Employer:	Name of Employer:
Work Address:	Work Address:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:

Identity Verification Information

If a person not listed below will need to pick-up your child, the information provided below will be utilized to verify your identity over the phone before any emergency instructions regarding the release and transport of your child will be accepted.

Charge Parent of Record (1)		Other Parent (2)	
Last 4 Digits of SSN	DOB	Last 4 Digits of SSN	DOB
Mother's Maiden Name	Child's Middle Name	Mother's Maiden Name	Child's Middle Name

Your name as well as your spouse's name must be listed below.
The below listed persons are authorized to pick-up and transport my child.

Name	Relationship to child	Phone
1.		
2.		
3.		
4.		
5.		
6.		

Signature:______________________________ Date: ____________

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/PacificIslander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian _______________ Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name________________________________ Birth Date______________ (mm/dd/yyyy) Date of Exam ______________ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT______in/cm______% ***Weight**_____lbs._____oz /_____% **BMI**_____/_____% *HC______in/cm______% (Birth – 24 months) *Blood Pressure________/_____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)

❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess

❑ Referral made to: ________________

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)

❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess

❑ Referral made to: ________________

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

*Result/Level: *Date

Other:

*TB: High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: ____________

Results:________________________

Treatment: ________________________

***Dental Concerns** ❑ No ❑ Yes

❑ Referral made to: ________________

Has this child received dental care in the last 6 months? ❑ No ❑ Yes

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced

❑ *If yes, please provide a copy of an **Asthma Action Plan*** ❑ Rescue medication required in childcare setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ____

Epi Pen required: ❑ No ❑ Yes

History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source

*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** ______________________

Seizures ❑ No ❑ Yes: Type: ________________ ______________________

❑ This child has the following problems which may adversely affect his or her educational experience:

❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*______________________________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:____________________________________ **Birth Date:**____________________ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) ____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) ____________________________________
(Date) (Confirmed by)

Exemption: **Religious** ______ **Medical: Permanent** ______ **†Temporary**______ **Date** _____
†Recertify Date __________ †Recertify Date __________ †Recertify Date __________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[2]	1 dose after 1st birthday[1]	1 dose after 1st birthday[2]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history	1 dose after 1st birthday or prior history	1 dose after 1st birthday or prior history	1 dose after 1st birthday or prior history	1 dose after 1st birthday or prior history
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[5]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009

Last Revised 3/13/17

Christ Lutheran Early Childhood Center
PHOTOGRAPHY PERMISSION FORM

Student Last Name:	Student First Name:

Please read the following and sign below:

I understand that all photos and video taken at Christ Lutheran Early Childhood Center may be used for promotional material, which includes but is not limited to: press releases, CLECC advertising, CLECC Newsletters, posting to CLECC's Facebook page, and CLECC's website.

Charge Parent of Record
Name:
Relationship to Child:
Signature:
Date:

CHRIST LUTHERAN EARLY CHILDHOOD CENTER
SERVICE CONTRACT

Student Name:	Student Date of Birth:

Please select a program: ☼

- ☐ Infant Room
- ☐ Waddler Room
- ☐ Toddler Room
- ☐ Pre-3
- ☐ Pre-Kindergarten
- ☐ Preschool Plus— M,W,F
- ☐ Before School
- ☐ After School
- ☐ Before &After School

Please check your child's schedule:

☼	Full Time (4-5 days a week)	Tuition(per week)
	Infant	$280.00
	Waddler Room	$280.00
	Toddler Room	$280.00
	Pre-3	$247.00
	Pre-Kindergarten	$247.00
	Before School	$50.00
	After School	$80.00
	Before & After School	$130.00

☼	Part Time (2-3 days a week)	Circle all that apply	Tuition
	Infant	M T W Th F	$70.00/day
	Waddler Room	M T W Th F	$70.00/day
	Toddler Room	M T W Th F	$70.00/day
	Pre-3	M T W Th F	$63.00/day
	Pre-Kindergarten	M T W Th F	$63.00/day
	Preschool Plus 9:00-12:30 (5 days a week)	M T W Th F	$125. Weekly
	Preschool Plus 9:00-12:30 Monday, Wednesday, Friday	M W F	$90. Weekly

**** Hours of arrival____________________ Departure __________________****

STUDENT NAME: ______________________

CHRIST LUTHERAN EARLY CHILDHOOD CENTER

SERVICE CONTRACT

I agree to abide by the CLECC policies as stated below. I agree to be responsible for the weekly tuition payments and fees as set forth in this contract. The above designated tuition is due every week regardless of the child's absence due to any reason or the center closing for holidays, weather or other unforeseen circumstances. I understand that advance payment is due on Monday by 6:00 p.m. for the following week's tuition. I further understand that payments received after 6:00 p.m. on Wednesday will be considered late and subject to and charged a $25 late payment fee. This fee will be applied weekly to accounts that are not current. I also understand that CLECC reserves the right to increase tuition rates and contractual fees and that they will provide a 30-day notice in instances where such increases are deemed necessary. In the occurrence of illness or absence, the Director or Administrative Assistant will be notified before the start of the child's session. Any advance notification of extended absences will be greatly appreciated. A 2-week written notice of a child's withdrawal is required. You will forfeit your security deposit if a 2-week notice isn't given. I agree to sign my child in when dropping off and out when picking up. The staff of CLECC will assume responsibility for my child from the time my child is signed into the program to the time my child is signed out. I agree to pick up my child on time and I understand that if I pick up my child after 6:00
p.m. I will be charged $25 for each 15 minutes (or any portion thereof) that I am late. I understand excessive occasions of late pick-ups may result in my child's dismissal from CLECC after 30-days written notice.

Start Date:____________________

Arrival Time:______________a.m./p.m. Pick up Time:______________a.m./p.m.

I agree to pay $______________per week for the following days:______________

______________________ ______________________________ __________

Parent Name (please print) Parent Signature Date