

City of Pembroke Pines Early Learning Programs Bright Beginnings

I/We hereby acknowledge receipt and examination of the Parent Handbook and state that I/We understand and agree to abide by all provisions contained therein, pages 3-11. I/We also understand that rules and regulations are subject to change without prior notice.

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

WHEN YOU ENROLL AT BRIGHT BEGINNINGS WE WILL PROVIDE YOU WITH A COPY OF OUR PARENT HANDBOOK

CITY OF PEMBROKE PINES
EARLY CHILDHOOD LEARNING PROGRAM
RELEASE AND WAIVER OF LIABILITY

Child's Name _____

It is hereby acknowledged that every possible precaution will be taken to safeguard my child while attending the City of Pembroke Pines Early Childhood Learning Center Bright Beginnings. For and in consideration of my child's participation and registration at the City of Pembroke Pines Early Childhood Learning Center Bright Beginnings, and on behalf of myself and my child, our respective heirs, administrators, executors and successors, I hereby covenant not to sue and forever release and hold harmless the City of Pembroke Pines, its officers, directors, agents and employees from any and all liability (including attorney's fees and costs) for any cause of action for personal injury, property damage or wrongful death occurring while my child is under the instruction, supervision or control of the City of Pembroke Pines including, without limitation, those damages or injuries resulting from acts of negligence on the part of the City of Pembroke Pines, its officers, directors, shareholders, employees or agents while my child is in attendance and on the premises at the Early Childhood Learning Center Bright Beginnings.

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

CHILDCARE APPLICATION FOR ENROLLMENT
(Page 1 of 2)

Student Information:

Date of Birth: _____ Sex: _____ Date of Enrollment: _____

Full Name: _____
Last First Middle Nickname

Primary Hours of Care: From _____ To _____

Days of the Week in Care: M T W Th F

Meals Typically Served While in Care: AM Snack & PM Snack

Parent provides lunch

Family Information:

Mother's Name: _____

Address: _____

Home Phone: _____

Employer: _____

Address: _____

Work Phone: _____

Cell Number: _____

Child Lives With: _____

Father's Name: _____

Address: _____

Home Number: _____

Employer: _____

Address: _____

Work Phone: _____

Cell Number: _____

Custody: Mother _____ Father _____ Both _____ Other _____

(Must provide legal court order documentation regarding custody, divorce, etc...)

Number of Children In Household: _____

Name(s) and Age(s) of brothers: _____

Name(s) and Age(s) of sisters: _____

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address: _____ Phone: _____

Doctor: _____ Address: _____ Phone: _____

Doctor: _____ Address: _____ Phone: _____

Hospital Preference: _____

Please list any allergies, special medication or dietary needs, or other areas of concern:

****YOU MUST INFORM EACH CLASSROOM IF YOUR CHILD HAS ALLERGIES!****

CHILDCARE APPLICATION FOR ENROLLMENT
(Page 2 of 2)

Contacts:

Child will be released to only the custodial parent(s) or legal guardian(s) 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.

Name	Address	Cell #	Home#
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Name	Address	Cell #	Home#
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Name	Address	Cell #	Home#
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Medical History:

Measles: _____ Mumps: _____ Chicken Pox: _____ Convulsions: _____

Any evidence of hearing difficulty: _____

Explain: _____

Any evidence of visual difficulty: _____

Explain: _____

Speech disabilities: _____ Explain: _____

Hospitalization: _____ Explain: _____

Operations: _____ Explain: _____

Other Illnesses: _____

Does your child have any physical handicaps or conditions which might affect his/her schooling? _____

Explain: _____

Briefly describe your child as a person: likes, dislikes, favorite pastimes, toys, friends, toilet habits, etc. In essence, please include anything that will help us understand your child and help him/her grow.

PARENT'S STATEMENT

In completing this application for my child to attend the City of Pembroke Pines Early Learning Childhood Program, I agree to support the moral, educational, and disciplinary standards of the school.

It is important for home and school to work together in establishing appropriate behavior. I give permission for my child to take part in all school activities, I will always be told of any field trips in advance and will sign a permission slip or my child will not be permitted to leave the school's premises. I agree to pay the tuition and any charges. I agree that I will **NOT** send my child to school sick. I also understand that this application cannot be considered without the registration fee.

In the event my child becomes ill or injured while under school supervision:

1. If the illness or injury is minor, the parent/guardian will be contacted.
2. If the illness or injury is more serious and/or life-threatening, 911 will be called.
3. Parent hereby release the City of Pembroke Pines Early Learning Childhood Program Bright Beginnings from any liability which might arise from giving of such authorization, it being the parent's desire to have child furnished with such medical or surgical services as soon as reasonably possible after the need arises.

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

DISCIPLINE POLICY

The City of Pembroke Pines Early Learning Childhood Program will ensure that age appropriate disciplinary practices shall be used for children in care.

Children shall not be subjected to discipline, which is severe, humiliating, or frightening.

Discipline shall not be associated with food, rest, or toileting.

Please sign below,

I _____, have read the Pre-school's discipline policy and have retained a copy.

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

Board of Broward County Commissioners, Broward County Florida
SOCIAL SERVICES DIVISION
CHILD/CARE PROGRAM ALTERNATE NUTRITION PLAN

Date _____

Name of Facility: Bright Beginnings
Early Child Development Center
Address: 901 N.W. 129th Ave.
Pembroke Pines, Florida 33028

Dear Parent,

In accordance with the Broward County Childcare Ordinance, parents and the childcare facility are urged to work cooperatively to assure that children are provided with nutritious snacks and meals where lunches are not provided by the facility.

Please read the following carefully, sign and return as soon as possible to the Site Supervisor.

The facility agrees to provide a nutritious:
(Director checks those which apply)

_____	Breakfast
<u> X </u>	Mid-morning snack
<u> X </u>	Mid-afternoon snack
_____	No meals or snacks

The parent agrees to provide a nutritious:

_____	Mid-morning snack
<u> X </u>	Lunch
_____	Mid-afternoon snack

I have read the preceding and agree to meet the child's nutritious needs as defined above.

Mary F. Peddy

Caretaker/School Director Signature

Parent/Guardian Signature

Nutrition Plan

(Parent - please tear and keep this portion)

Meals provided by parents ought to consist of the following:

- | | | |
|----|--------------------------|--|
| A. | Meat/Poultry/Fish | 2 ounces |
| | Or cheese | 2 ounces |
| | Or eggs | 1 egg |
| | Or dried beans and peas | $\frac{1}{2}$ cup |
| B. | Fruits (2 or more) | $\frac{1}{2}$ cup |
| | Or vegetables | $\frac{1}{2}$ cup |
| | Or fruits and vegetables | $\frac{3}{4}$ cup total amount and Vegetables must equal $\frac{1}{4}$ cup |
| C. | Bread | 1 slice |
| D. | Butter | 1 teaspoon |
| E. | Milk | 1 cup - 8 oz. |

MEDICAL TREATMENT

Dear Parent,

In order to comply with the Broward County Child/Care Code, please provide us the following information. Our preschool shall have written instructions from parents for the school to follow in arranging for immediate treatment for your child in an emergency situation.

Below, you will find the necessary form that will need to be filled out for our records. If you have any questions concerning this matter, please feel free to contact us. Thank you in advance for your cooperation.

1. By my signature below, I give the preschool authorization to seek medical treatment for my child if I or any other persons for whom I have listed to be notified in case of emergency cannot be reached.
2. By my signature below, I give any health facility or physician permission to provide medical treatment for my child as necessary in any emergency situation, which may arise at the preschool.
3. By my signature below, I will take full responsibility for payment of all medical services, which might be rendered due to any emergency situation that may arise at the preschool.

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

MEDIA RELEASE

From time to time during the school year, the media and the graphics department photograph our school, staff, and students to visually explain the many and varied types of programs and events which the City of Pembroke Pines offers. Those photographs or videotapes may be used in newspapers, on television, or in other appropriate publications.

Your signature below indicates your permission for your child to be photographed for such purposes.

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

Allergy List

I would like to advise you that

(Child's Name)

Is allergic to the following:

Other things I would like you to know about my child are:

THANK YOU!

Bright Beginnings
901 N.W. 129th Ave
Pembroke Pines, FL 33028

Dear Parent or Guardian:

Our infant napping policy has changed in compliance with the Broward County Child Care Facility Ordinance 2004-2 Sec 7-5.04 Napping Space paragraph (f):

"When napping or sleeping, any infants that are not capable of rolling over on their own, should be positioned on their back on a firm surface to reduce the risk of Sudden Infant Death Syndrome, unless an alternate is authorized in writing by a physician. The documentation shall be maintained in the child's records."

We apologize for any inconvenience this may cause, but we are now required to get a doctor's note for a child to sleep in any other position than noted above.

Sincerely,

Susan Munro
Infant Room Lead Teacher

Student's Name: _____

Parent/Legal Guardian Print Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

***FORM ONLY TO BE COMPLETED FOR STUDENT
ENROLLED IN INFANT ROOM***

FACILITY BROCHURE STATEMENT
(Chapter 402.3125, F.S.)

On _____
(Date)

I _____, received a copy of the Childcare Facility
Brochure (Parent's name)

(Signature of Parent/Legal Guardian)

(Name of Child)

This information is for Day Care facility file.

MEMO

TO: ALL PARENTS
FROM: FINANCE DEPARTMENT
SUBJECT: PAYMENT BY CHECK NEW POLICY
DATE: 2/1/2005

Effective immediately we are implementing the following new check payment policy.
Attached please find:

1. Check Payment Policy. (For your records)
2. Payment Agreement Form.

The Payment Agreement Form must be executed and returned to the front office. The Payment Agreement form must be returned to the City in order for your child to continue to participate at the early learning center.

Please note that all of your future check payments will be compared against a citywide database of checks returned unpaid. Anyone, whose name appears in this database, will have their checks returned to them and be referred to the policy for further instructions.

Thank you for your cooperation in this matter.

Check Payment Policy

A. The maker of each dishonored check returned to the City of Pembroke Pines will be assessed the returned check services charge as provided for in 166.251, Florida Statutes, as amended from time to time. 166.251, Florida Statutes provides for the following fees:

- (a) Twenty-five dollars, if the face value does not exceed \$50
- (b) Thirty dollars, if the face value is more than \$50 but does not exceed \$300
- (c) Forty dollars, if the face value is more than \$300 but does not exceed \$800
- (d) 5% of the face value if the face value exceed \$800

B. Service charge waivers: Any Department Director may elect to waive the Non-Sufficient Funds (NSF) service charge if the check is returned as a result of one of the following

- (a) Bank error - a written explanation from the bank must be provided.
- (b) Department error - the department failed to deposit check within 90 days of the receipt.
- (c) Fraud or stolen check - a police report must be provided.

C. In accordance with 68.065, Florida Statutes, appropriate civil legal actions may be filed against the maker of the dishonored check if full payment is not made within thirty (30) days of receiving notice of the returned check. The legal action could result in an award to the City in the amount up to three (3) times the amount of the check, but in no case less than fifty (\$50.00), in addition to the payment of the check plus any court costs, reasonable attorney's fees, and any bank fees incurred by the City.

D. Checks and returned check fees must be paid in cash, money order or cashier's check made payable to the City of Pembroke Pines. A returned check cannot be paid by another check even if the other check is drawn from a different bank.

E. When a customer issues three (3) returned checks on any City account during the most recent twelve (12) months, his/her check payment privileges at the City of Pembroke Pines will be suspended for a period of six (6) months.

F. Subsequent returned checks received after the reinstatement of check writing privileges, will result in an additional six (6) months suspensions.

G. Departments should not accept the following checks:

- Temporary Checks (They do not have any information printed on them).
- Checks without a complete address.
- Postdated checks (A check with a future date) or stale check (A check that is older than 6 months).
- Incomplete or illegible checks (All checks must be dated. If no date, date it).
- Checks that only have one signature where two are required (Stated on the face of the check).
- Foreign Checks.
- Third party checks.

H. Refund payment requests received in Accounts Payable will be verified against the return check database (SmartCheck). Anyone whose name appears in this database will have his or her refund adjusted accordingly to satisfy the balance due to the City for any dishonored check(s). In the event that this adjustment reflects a refund to the customer, the request will then be forwarded to Accounts Payable for payment.

SWIM Central Water Safety Education Questionnaire

Child Care Facility: _____ Date: _____

Child's Name: _____ Age: _____

Parent's Name and Address: _____

- 1. Has your child ever taken swim lessons? Yes ___ No ___
- 2. Can your child roll over and float on his/her back? Yes ___ No ___
- 3. Can your child swim to the side of the pool? Yes ___ No ___
- 4. Have you taken a Community Water Safety Course? Yes ___ No ___
- 5. Is anyone in your household certified in CPR? Yes ___ No ___

Additional Comments: _____

Please mail or fax back to: SWIM Central
950 Northwest 38th Street
Oakland Park, Florida 33309

Fax Number: (954) 357-8102

***THIS FORM IS TO BE FILLED OUT FOR ALL STUDENTS ENROLLED**

Dear Parents,

At the City of Pembroke Pines Early Learning Center Bright Beginnings campus we are always striving to find ways of keeping up with the times and keeping our parents abreast of the latest school news and activities.

For this reason we are implementing an electronic mail service that will allow us to send you information as it becomes available. If you would like to be added to our mailing list please fill out this form and return it with your e-mail address as soon as possible.

Student's Name: _____

Mother's Name: _____

E-Mail: _____

Work E-mail: _____

Father's Name: _____

E-Mail: _____

Work E-mail: _____

Legal Guardian Name: _____

E-Mail: _____

Work E-mail: _____

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Father's Name: _____

E-Mail: _____

Work E-mail: _____

Legal Guardian Name: _____

E-Mail: _____

Work E-mail: _____