SandCastles Rates

Non-refundable Registration Commitment fee of $50 is due at time of registration

Seahorses 12 – 24 months

____ Full time $655 per month

____ M-W-F $465 per month

____ Tu-Th $330 per month

____ Mornings* $410 per month

____ Afternoons** $410 per month

Seahorses 25 – 36 months

____ Full time $630 per month

____ M-W-F $445 per month

____ Tu-Th $315 per month

____ Mornings* $395 per month

____ Afternoons** $395 per month

*Mornings: 7:00 am – 12:30 pm

**Afternoons: 12:30pm – 6:00pm

Dolphins 3 years – 5 years

____ Full time $605 per month

____ M-W-F $430 per month

____ Tu-Th $305 per month

____ Mornings* $380 per month

____ Afternoons** $380 per month

Dolphins Kindergarten Readiness

____ Full time $625 per month

____ M-W-F $445 per month

____ Tu-Th $320 per month

____ Afternoons only** $400 per month

Sharks School Age

____ Before/after school $290 per month

____ Summer $615 per month

Parents' Names

Child's Name Birthdate

Address City Zip

Home phone Cell Email

For Office Use

Interview Date ____

Registration Fee Paid Date ____

Start Date ____

SandCastles, Inc.

Information Sheet

Child's Information: ____
First Middle Last Birthday

- Address ____
- City, State Zip ____
- Home Phone ____
- Lives with: ____

____

- Second Child: ____
First Middle Last Birthday
- Third Child: ____
First Middle Last Birthday

Please fill out additional Medical and Personal Information for each child.

Parent or Guardian's Information:
Sponsor – *Financially Responsible Party*
Co-Sponsor- *Other Party*

☐ Sponsor
☐ Co-Sponsor

- **Mother's Name:** ______________________ Birthday: ____________
- Address ____
Street City Zip
- Home Phone: ______________ Cell Phone: ______________
Work Phone: ______________
- Email: ____
- Occupation: ______________________ Employer: ____________
- Emergency phone contact: ____
- Step parent or significant other: ______________________ Birthday ____________
- Occupation: ______________________ Employer: ____________
- Work Phone: ____________ Cell Phone: ________ E-Mail ____________

☐ Sponsor
☐ Co-Sponsor

- Father's Name: ______________________ Birthday: ________________
- Address ____
  Street City Zip
- Home Phone: ________________ Cell Phone: ________________
  Work Phone: ________________
- Email: ____
- Occupation: ______________________ Employer: ________________
- Emergency phone contact: ____
- Step parent or significant other: ____________________ Birthday ________________
- Occupation: ______________________ Employer: ________________
- Work Phone: ____________ Cell Phone: ________ E-Mail ________________

- Are there any Restraining orders or visitation limitations with non-custodial parent? ______________________
- Please attach any legal document or written instructions that we need to be aware of.

Check in Codes for our Computer Check in System & Keyless Entry

Please choose a 4 number code for each person that will be picking up or dropping off your child. A different code per person is a must because it enables us to track who dropped off and picked up. This information will be kept in a secure file. In the box next to each name please indicate by T, M, or L which level you want that person to be. The levels are explained below:

Top Level will receive	Medium Level	Low Level
Messages Billing Information Immunization Information	Messages	No Information

☐ Mother: __ __ __ __
☐ Father: __ __ __ __
☐ Step Father: __ __ __ __
☐ Step Mother: __ __ __ __

Additional Pick Up:

☐ __ __ __ __Name:________
☐ __ __ __ __Name:________
☐ __ __ __ __Name:________
☐ __ __ __ __Name:________
☐ __ __ __ __Name:________
☐ __ __ __ __Name:________

Medical Information:

- Doctor: ____
  Name Address Phone
- Dentist: ____
  Name Address Phone
- Hospital Preference: ____
  Name Address Phone
- Insurance Information: ____
  Company Plan # Group #
- Date of Last Physical:

Please bring in or attach a current copy of the Immunization Card

- Was there anything unusual about the pregnancy with this child?

____

____

- Was this child full term: ____________ Birth Weight: ____________
- Did this child require any special medical care or prolonged hospitalizations at birth? ____________ Please Explain: ____________

____

Developmental Information:

At approximately what age did this child:

- ☐ Sit unassisted ________
- ☐ Crawl ________
- ☐ Feed self ________
- ☐ Drink from cup ________
- ☐ Walk Alone ________
- ☐ Dress Self ________
- ☐ Say first words ________
- ☐ Say first sentence ________

- Does your child (check all that apply):

- ☐ Suck thumb or fingers
- ☐ Have temper tantrums
- ☐ Wet the bed
- ☐ Hold breath
- ☐ Have regular nightmares
- ☐ Twirl hair
- ☐ Sleep walk
- ☐ Wander off
- ☐ Cry easily
- ☐ Like a challenge
- ☐ Timid
- ☐ Have difficulty with separation
- ☐ Need comfort blankie or toy

Illnesses:

- Have either you or your doctor noted that your child has had (check all that apply):

☐ High Fevers
☐ Fibular Seizures
☐ Epileptic Seizures
☐ Tooth or Mouth Problems
☐ Speech Problems
☐ Nose Bleeds
☐ Difficulty Seeing
☐ Difficulty Hearing
☐ Frequent Colds
☐ Eczema
☐ Hives
☐ Wheezing
☐ Chronic Vomiting or Diarrhea

If yes to any above, please explain how often it occurs, cause and treatment given: ______

____

____

- Has your child had any of the following illness (check all that apply):

☐ Chicken Pox
☐ Meningitis
☐ Red or Hard Measles
☐ Strep throat
☐ German or 3 day Measles
☐ Impetigo
☐ Mumps
☐ Pin Worm

Has this child ever been hospitalized or had surgery: ______________________________

____

Please list all allergies - Food and medication:

____

____

Personal Information:

- Child's Favorite Things: ____
- Child's Favorite Foods: ____
- Child's Least Favorite Foods: ____
- Child's Favorite Friends: ____
- Child's Fears: ____
- Method of Discipline or Guidance at Home: _______________________________

____

- Have you ever attended a Parenting Class? _______________________________
- Which one? ____
- Was it useful? ____

➢ Is there any special information which would help us understand your child and their preschool needs? ____

____

____

____

____

____

____

➢ How did you here about SandCastles, Inc?

- ☐ Referred by ______________________________
- ☐ Phone Book ______________________________
- ☐ Advertisement______________________________
- ☐ Other: ______________________________

➢ Why did you ultimately choose us?

- ☐ NAEYC Accreditation
- ☐ Low Ratios
- ☐ Other ______________
- ☐
- ☐ Teacher Qualification
- ☐ Field Trips:
- ☐ Parent Involvement

Request for Medical Records
SandCastles
Fax: 208-376-7847

I ____________________ hereby authorize

Dr. ____________________________ @ ______________________________________
Medical Practice or Group Name

____
Phone # Fax#

____
Address

to release my child's most current Medical Physical to my child care provider, SandCastles, Inc 3214 Acre Lane, Boise ID 83704, 208-376-7846 or
FAX to 208-376-7847 within 10 days of receiving this request.

____
Child's Name Birth date

____
Child's Name Birth date

Print: ____
Parent's Name

Signed: ____
Parent's Name

____
Address

____
Phone

Can use attach sheet or Doctor's Form
Information should include as follows:

- Date of Physical
- Height
- Weight
- Any Significant findings in regards to child's health.
- Any potential concerns to be monitored.
- Allergies

For Office Use	
Date Requested:	
Date Received:	
2nd Request:	
3rd Request:	

Physical / Health Records
SandCastles Inc

Child's Name:______________________________ Date of Physical: ______________

Height: __________________ Weight: _______________________

Please Check Appropriate Response:

Child's Health
_____ Fair
_____ Good
_____ Excellent

Any Significant findings or health concerns that are being monitored:
____
____
____
____

List Allergies:
____
____
____
____

Date next physical is due: _______________________________

Signature to Admission at SandCastles, Inc

I agree to cooperate with the general polices of the center, to perform the obligations of the parents or guardians set forth in this agreement, and to abide by the rules, regulations, and manuals promulgated and provided by the center. My signature below indicates that I have read the terms of this agreement and that I have read the rules and regulations and the manual promulgated and provided by the center. It further indicates that I had this material explained to me and that all of my questions have been satisfactorily answered.

Initial Here:_______

Agreement to Policies:

I have read all the material given to me by SandCastles and I agree to the policies set forth.
I understand and agree by my initials to the:

_____Admission Policy *pg. 2 of the handbook*

_____Drop off and Pick up Policies *pg. 3 of the handbook*

_____Withdrawal Policy *pg. 4 of the handbook*

_____Discipline Policy *pg. 5 of the handbook*

_____Health Policy *pg. 6 of the handbook*

Payment Agreement:

I have received and read a copy of the payment policy. *Pg 10 of the handbook.*
I understand that my rate for the year _______________ will be ___________ per month.
I understand that payment is due by the 1st of the month.
Unless specified here: ____

I also understand the late charges and actions that will be taken if I have an unpaid account.

Special considerations

I am subsidized by ICCP __________ Health & Welfare ___________ Other ______

- If subsidized I will agree to pay in advance all tuition fees and understand that when subsidy payment is made I will be reimbursed or amount applied towards the next month unless other arrangements have been made. I understand that I am responsible for the total amount and unpaid balances will be pursued as outlined in the payment agreement.

Initial Here: _____

Emergency Statement:

In case of an emergency, where you are unable to reach any of my phone numbers, you have my permission to contact another local licensed physician if our family physician is not available, or take my child to a hospital for emergency treatment.

Initial Here: _____

Field Trips:

I understand that field trips are an important and regular part of SandCastles Preschool program. I also understand that every child will be placed in a child restraint seat or seat belt depending on age and weight as defined by Idaho State law.

Initial Here: _____

I hereby agree to all the above:

Parent or Guardian Signature Date

Director Signature Date

IRIS Idaho's Immunization Reminder Information System

Consent Form

Signing the statement below will permit the health care provider who immunizes me or my child to submit information about those immunizations and me or my child to the voluntary Idaho Immunization Reminder Information System (IRIS). This information will be limited to identifying information (such as name and date of birth), immunization information (such as dates and types of immunizations), and location information (such as my correct address). To make sure the correct immunizations are provided, my immunization records—or my child's—may be made available to health care providers, child care providers, or schools.

My consent permits my child's or my own **enrollment** in the statewide immunization registry. I may be asked for information that will help ensure records are accurate and will not be confused with another person's, such as:

Mother's maiden name;
Gender;
Other data to determine my child's eligibility for free vaccine

My consent also will allow for the **transfer** of my or my child's previous immunization records into the statewide registry.

IMMUNIZATION HISTORY SHOULD ACCOMPANY CONSENT FORM

I give permission to **enroll** me or my child and to **transfer** my or my child's immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to me, my or my child's health care providers, child care providers, and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into **IRIS**.

Child's Name or My Name		Date of Birth
Address		Telephone Number
Signature	Relationship to Child (if applicable)	Date

Sistema de Información para el Recordatorio de las Vacunas en Idaho

Permiso

Mi firma en este documento autoriza al proveedor del cuidado de salud que me está vacunando a mí o a mi hijo, que dé información acerca de esas vacunas al Sistema de Información para el Recordatorio de las Vacunas (Idaho Immunization Reminder Information System o IRIS). Esta información será limitada a la indetificación de la persona (como el nombre y la fecha de nacimiento), información sobre las vacunas (como las fechas en que fueron dadas y los tipos de vacunas) y sobre el lugar (como mi dirección correcta).

Para asegurarse de que se están administrando las vacunas correctas, mi registro de vacunas—o el de mi hijo—puede estar disponible a los proveedores del cuidado de la salud, a los proveedores del cuidado infantil o a las escuelas.

Mi consentimiento permite mi registro, o el de mi hijo, en el registro estatal de vacunas. Tal vez me pidan información para que les ayude a asegurarse de que los registros están correctos y de que no serán confundidos con los de otra persona, tales como:

Apellido de soltera de mi madre
Sexo
Otra información para determinar la elegibilidad de mi hijo para recibir vacunas gratis

Mi permiso también permitirá que los registros de las vacunas anteriores mías o de mi hijo sean transferidas al registro estatal.

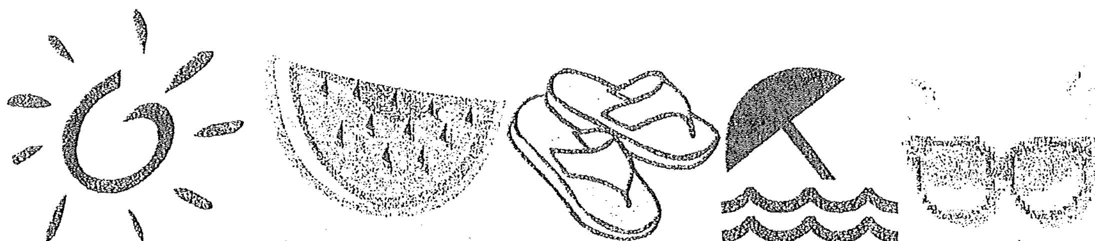
La tarjeta de vacunación debe de acompañar la forma de consentimiento.

Yo doy permiso para que registren mi nombre o el de mi hijo y para que transfieran mis registros de vacunas o los de mi hijo al Sistema de Información para el Recordatorio de las Vacunas para asegurarse de que este registro de vacunas está disponible para mi uso, para el proveedor del cuidado de la salud mío o el de mi hijo, para los proveedores del cuidado infantil y para las escuelas. Comprendo que tal vez me pidan información para que puedan mantener los registros correctos y que no sean confundidos con los de otra persona, como: el nombre de soltera de mi madre, número de teléfono, sexo y la elegibilidad de mi hijo para recibir vacunas gratis. Yo autorizo la inclusión de toda esta información en el IRIS.

Nombre de mi Hijo or Mi Nombre — Fecha de Nacimiento

Dirección — Número de teléfono

Firma — Parentesco al Niño (si aplica) — Fecha



Sunscreen Consent Form

Childs Name: ______________________ Date: ____________________

I hereby give Sandcastles permission to apply sunscreen in accordance with the directions for use on the container:

[ ] Sunscreen*

Specify frequency and duration of use:

____

____.

Special Instructions:

____

____.

This consent is valid from today until ______________________. I may withdraw this request at anytime.
I release Sandcastles form any liability for administering these preparations.

Parent/ Guardian: ______________________ Date: ________________

- Denotes items to be supplied by parents if use is requested.

IT IS OUR POLICY THAT YOU MUST APPLY SUNSCREEN TO YOUR CHLD BEFORE THEY ATTEND EACH MORNING. WE WILL REAPPLY THE SUNSCREEN IF THEY GO OUTSIDE IN THE AFTERNOON.

3076 N. Five Mile • Boise, Idaho 83713 • (208) 376-4999 • Fax: (208) 376-4988

REQUEST FOR RELEASE AND CONSENT TO FILM AND SHOW VIDEO/PICTURES/SLIDES

Dear Participant/Parent(s)/Guardian(s)/Care Providers:

Community Partnerships of Idaho is creating a video/slide show/picture album to use in training activities, both in the office and in the community.

In order to do this, we need your specific permission to film and then show the video/slide show/pictures. The presentation will only be used in professional settings such as conferences, staff orientation, job specific training, and promotional exhibits such as volunteer fairs, job fairs, etc.

Please check the appropriate box below and sign the applicable line. Thank you.

CONSENT AND RELEASE TO FILM AND SHOW VIDEO/PICTURES/SLIDES

________ Yes, I give my consent for Community Partnerships of Idaho to film and show the video/slide show/pictures in a professional setting, such as conferences, staff orientation, job specific training, and promotional exhibits such as volunteer fairs, job fairs, etc. In giving my consent, I recognize that the video/slides/pictures will be used in public settings and that there is not a time limit on the usage by Community Partnerships of Idaho. My consent releases Community Partnerships of Idaho from all liability associated with public exposure.

________ No, I do not wish to give my consent for Community Partnerships of Idaho to show the video/slides/pictures in professional settings.

Name of Participant:____

Signature of Participant:____

Signature of Parent/Guardian/Care Provdier:

____

Date:______________________

Confidentiality Policy

I am aware that during the course of my child's time at SandCastles Early Learning Center, my child's information regarding medical information, individual child development assessments , and other information will be used only by SandCastles director and staff, Boise city licensing and Central District Health Inspectors during annual licensing renewals in August, and in case of an emergency medical personnel.

____

Print Parent/Guardian Name

_______________________________________ ______________

Parent/Guardian Signature Date

3214 Acre Lane * Boise, Idaho 83704 * (208) 376-7846 * Fax: (208) 376-7847

Transportation Release

THE UNDERSIGNED, in consideration of the provision of transportation by SandCastles Early Learning Center/Community Partnerships of Idaho, Inc. and its employees to and from home and/or community destinations incidental to the provision of services being received, agrees to release and waive any claim for damages that might be sustained by the client while being transported.

Client_______________________________ Date______________________

Parent/Guardian______________________ Date______________________

Witness_____________________________ Date______________________