YOUR CHILD, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, HAS BEEN ENROLLED IN THE GET WELL PLACE FOR SICK CHILD CARE. THE FEE FOR THIS PROGRAM IS $ \_\_\_\_\_\_ PER FULL DAY VISIT (MORE THAN 5 HOURS) AND $ \_\_\_\_\_\_ PER HALF DAY VISIT (5 HOURS OR LESS).

I hereby represent that I am the legal guardian of the child enrolled. I acknowledge that it is my responsibility to keep all information and authorizations pertaining to my child up to date. In addition, I understand that since LeafSpring School and The Get Well Place employees are bound by contract and not available for full time employment by enrolled parents, I will not attempt to make regular on going employment arrangements with them.

I understand that full payment is due on the day of each visit. If debt collection services become necessary, LeafSpring School and The Get Well Place reserve the right to charge a $250.00 administrative debt collection fee, for which I will be responsible. I will also be liable for any court costs, attorney and other legal fees associated with the collection process.\*

I have read and understand the fee arrangements, the Get Well Place parent handbook and the policy statements on this form. I am in agreement with these policies and will abide by them and any additions that may arise after enrollment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/LEGAL GUARDIAN SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIRECTOR SIGNATURE DATE

\*Both parents/guardians listed on the registration form will be held financially responsible for all fees.

CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELEASE OF MEDICAL INFORMATION

* I authorize LeafSpring School to obtain medical information from my physician concerning my child.
* I authorize the following individuals to have access to my child’s health information *in case of emergency only*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name / Relationship to Child Name / Relationship to Child

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

* I authorize LeafSpring School to obtain all necessary care for my child.

Name of Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_

ALLERGY INFORMATION RELEASE

* I authorize LeafSpring School to post the picture, name and allergy of my child with allergies strategically throughout campus, including but not limited to the Classrooms (Preschool or Village), Dining Car, Kitchen and the Get Well Place. I understand that this signature applies toward current and/or any future allergies.

STUDENT EXPERIENCES

* I understand that LeafSpring School serves as a training site for local colleges and universities. I authorize that my child may be involved in selected, supervised student teaching experiences.

ILLNESS

* **Get Well Place Children:**

In the event that my child’s condition exceeds criteria for care in the Get Well Place, I agree to make arrangements to have him/her picked up within one hour. I furthermore agree to notify LeafSpring School in the event that my child or any of my family members has been exposed to a communicable (contagious) disease.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date