



**Yvonne Learning Center**  
Enrollment Registration Form Page 2

(You are required to fully complete all parts of this application - Please print or type - Signatures Required)

With whom does the student live \_\_\_\_\_

Name and address of the person financially responsible for student's tuition and fees, if different than parent or guardian:

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Name	Address	Zipcode
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Phone No.	Cell No.	Alt. No.
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Has the student been on probation, suspended, dismissed or withdrawn from any school? \_\_\_\_ Yes \_\_\_\_ No

If yes, please attach a statement giving the name of the school and relevant details:

How did you learn about Yvonne Learning Center? \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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**For Office Use Only**

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Registration Fee Paid \$ \_\_\_\_\_ Date \_\_\_\_\_ Cash \_\_\_\_\_ Ck#: \_\_\_\_\_ MO# \_\_\_\_\_

Enrollment Packet Complete \_\_\_\_ Yes \_\_\_\_ No Student Accepted: \_\_\_\_ Yes \_\_\_\_ No

**YVONNE LEARNING CENTER**  
**KNOW YOUR CHILD CARE CENTER BROCHURE**

**Helpful Information About Your Child:**

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Section 65C-22.006(2), F.A.C., requires a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.

Section 402.3125(5), F.S., requires that parents receive a copy of the Child Care Facility Brochure, "KNOW YOUR CHILD CARE CENTER".

By signing below, you verify that you have received the above items and that all information on this enrollment form is complete and accurate.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

YVONNE LEARNING CENTER

CONTACT INFORMATION FORM

**CONTACTS:** Child will be released only to the custodial parent or legal guardian 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:

Custody: Mother\_\_\_\_\_ Father\_\_\_\_\_ Both\_\_\_\_\_ Other\_\_\_\_\_

1. \_\_\_\_\_  
Name Address Relationship to Child

Work# Cell# Home#

2. \_\_\_\_\_  
Name Address Relationship to Child

Work# Cell# Home#

3. \_\_\_\_\_  
Name Address Relationship to Child

Work# Cell# Home#

4. \_\_\_\_\_  
Name Address Relationship to Child

Work# Cell# Home#

YVONNE LEARNING CENTER

EMERGENCY CONTACT INFORMATION FORM

**Child Information:**

\_\_\_\_\_  
Last Name First Name Date of Birth:

**Mother Information:  
(or legal guardian)**

\_\_\_\_\_  
Last Name First Name

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Phone#: Cell#:

**Father Information:  
(or legal guardian)**

\_\_\_\_\_  
Last Name First Name

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Phone#: Cell#:

**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.)

Child's Doctor Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Child's Doctor Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Medical Carrier: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Any medication your child is currently taking: \_\_\_\_\_

Are there any known allergies, health or medical conditions that YLC should be made aware of? Circle YES or NO if yes please describe:

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

**PARENT CONSENT:**

In the event that my child needs immediate attention for injuries, sudden illness, or emergency, and medical treatment, I give YLC staff authorization to act on my behalf in securing proper medical treatment. YLC may also admit my child to a hospital emergency room for emergency medical treatment without my consent if I cannot be reached to give permission. I understand that I am financially responsible for any expenses or medical care or transportation incurred on my child's behalf. I release YLC staff, Board of Directors, volunteers and all funding sources from liability or legal action. I understand and fully give my consent.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Yvonne Learning Center

**AUTHORIZATION FOR MEDICAL TREATMENT**

I/We request that in my/our absence \_\_\_\_\_ is  
to be admitted to \_\_\_\_\_ **hospital** for diagnosis and treatment and hereby give  
my permission for Yvonne Learning Center to transport my/our child to the above mentioned hospital or to the nearest  
hospital for treatment.

Date of last tetanus immunization: \_\_\_\_\_ Medication taken daily \_\_\_\_\_

Family Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Under the name of \_\_\_\_\_

My child has a history of the following chronic medical problems (Example: asthma, allergies, drug related allergies,  
heart condition, epilepsy, sickle cell, etc.) \_\_\_\_\_

Special information or instruction for emergency care: \_\_\_\_\_

Are there any other physical or medical conditions we should know about not already stated: \_\_\_\_\_

**The office staff of Yvonne Learning Center has my permission to administer medication sent from home with a  
signed note and instructions.**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

# Yvonne Learning Center

## **Student Family Information**

Parent/Guardian Name \_\_\_\_\_

Home No. \_\_\_\_\_ Work No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Home No. \_\_\_\_\_ Work No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Address: \_\_\_\_\_

**Please list all siblings presently attending YLC Private School or YLC Daycare Center**

<b>Last Name</b>	<b>First Name</b>	<b>Grade entering</b>
1. _____	_____	/ _____
2. _____	_____	/ _____
3. _____	_____	/ _____
4. _____	_____	/ _____

**If there are any changes during the year YLC must be notified in writing immediately.**

**The persons listed below are also authorized to pick up my child**

Emergency contact name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home No. \_\_\_\_\_ Work No. \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home No. \_\_\_\_\_ Work No. \_\_\_\_\_

**Other local relatives or close friends we can contact when the above cannot be reached:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Alt No. \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Alt No. \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Alt No. \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Alt No. \_\_\_\_\_

Yvonne Learning Center

AUTHORIZATION FOR PHOTOGRAPHY / VIDEO

I, \_\_\_\_\_, the parent or guardian of  
\_\_\_\_\_ (Child), hereby authorize and give consent to Yvonne Learning Center as follows:

I hereby consent and authorize the staff of Yvonne Learning Center to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotaped recordings (hereinafter recordings) of me, my children, or my wards for educational, research documentary and public relations purposes. Any such recordings may reveal my identity through the image itself without any compensation to me, my children or my wards.

Any and all Recordings taken of me shall be the sole property of Yvonne Learning Center. With regard to the use of any Recordings taken of me, my children or my wards, I hereby waive any and all present and future claims I may have against Yvonne Learning Center, their staff, employees and Board members.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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**I Decline Authorization for Photography/Video for my child** \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

# YVONNE LEARNING CENTER

## Annual Field Trip Release Form



This form will be maintained on file in the school office and will serve as permission for all of the off campus trips during the school year.

I/We give permission for \_\_\_\_\_ grade \_\_\_\_\_ to participate in all school and sports-sponsored trips away from the school premises for the duration of the aforementioned year. Students will be accompanied by a teacher and/or coach and will be under adequate supervision.

I/We recognize that there are risks associated with the participation of any off campus trip and the associated activities. In consideration of this, I/We assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/We hereby give permission for my/our child to travel by school provided transportation while participating in the activities sponsored by Yvonne Learning Center.

I/We authorize the adult in whose care my/our child has been entrusted, to consent to any x-ray, examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care to be rendered to my/our child under the general and special supervision and on the advise of any physician or dentist, licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital and/or emergency care facility, whether such diagnosis or treatment is rendered at the office of said physician or said hospital. I/We do herewith authorize the treatment by this authority and grant it only after a reasonable effort has been made to reach me/us. I/We give permission for Yvonne Learning Center staff to immediately call paramedics and then contact me/us as soon as possible thereafter.

I/We, the undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to my/our child pursuant to this authorization. My/our signature(s) also serves to indicate my/our willingness to take full responsibility for any and all medical services rendered for my/our child. Should it be necessary for my/our child to return home due to medical reasons or otherwise, I/We shall assume all transportation costs.

I/We do hereby release and agree to hold harmless Yvonne Learning Center and their directors, employees or representatives, including volunteers from any and all liabilities or claims for personal injury, illness, or death as well as property damage and expenses of any nature whatsoever which may be incurred by my/our child while participating in activities sponsored by Yvonne Learning Center.

Father/Guardian's Name (print) \_\_\_\_\_

Father/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Mother/Guardian's Name (print) \_\_\_\_\_

Mother/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**If the child lives with both parents/guardians, the release must be signed by both parents/guardians.**



# MEDICAL HEALTH HISTORY

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_

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Illnesses: (please circle)

Does your child have any problems with any of these?

Constipation  
Convulsions  
Diarrhea  
Fainting Spells  
Frequent Colds  
Frequent Ear Infections  
Frequent Sore Throats  
Lice  
Ringworm  
Skin Rash  
Soiling  
Stomach Upsets  
Urinary Problem  
Worms

Has your child had any of these diseases?

Asthma  
Bronchitis  
Chicken Pox  
Diabetes  
Heart Disease  
Hepatitis  
Impetigo  
Measles  
Mumps  
German Measles  
Polio  
Scarlet Fever  
Tuberculosis  
Whooping Cough

Is your child currently taking any medications?  Yes  No (if yes, please list)

Other ILLNESSES (besides above) \_\_\_\_\_

Has your child been HOSPITALIZED? (explain) \_\_\_\_\_

Has your child had INJURIES with fractures or loss of consciousness? (explain)

\_\_\_\_\_  
Last VISION Test Date: \_\_\_\_\_ Last HEARING Test Date: \_\_\_\_\_

Any other members of your family with SERIOUS ILLNESS recently? \_\_\_\_\_

Any other members of your family with history of: ASTHMA \_\_\_\_\_ DIABETES \_\_\_\_\_ EPILEPSY \_\_\_\_\_

# YVONNE LEARNING CENTER



## FINANCIAL AGREEMENT

Child's Name \_\_\_\_\_ Age \_\_\_\_\_

I, \_\_\_\_\_, agree to the following payment policies in order to have my child(ren) enrolled in Yvonne Learning Center.

I agree to pay a **registration fee** of \$\_\_\_\_\_ upon registering my child(ren) at Yvonne Learning Center. I understand a registration fee is due each Spring in order to reserve my child's place for the Fall. (A summer registration fee will be assessed for students enrolled in the center only for the months of June, July and August)

I agree to pay a **security deposit** equal to one week's tuition upon registering my child. I understand this is a one time fee and will be applied to my child's last week at the center if no payments are delinquent and a full two week written notice of withdrawal is given.

I agree to pay the **weekly tuition** fee of \$\_\_\_\_\_ in full every **Monday** morning prior to leaving my child at the center. I understand that payment is due every Monday unless my child is ill or the center is closed regardless of my child's attendance schedule. Furthermore, I understand that once tuition is paid, there are no refunds and that payment should be made by check or money order. If tuition is not paid on time (by 9:00 a.m. Wednesday morning) a **\$15.00** late fee will be charged. If payment is not received by Friday at close of business child will not be allowed to attend school until past due tuition and late fee is paid in addition to the following week's payment.

I understand that the center's hours of operation are **Monday through Friday 6:30 a. m. – 6:00 p.m.** Should I pick my child up after 6:00 p.m. I agree to pay a **late fee** of **\$5.00** for each five (5) minutes or fraction thereof after 6:00 p.m. in which my child remains at the center. I understand this late pick up fee is due at the time I pick up my child or before returning my child to the center.

Children who are sponsored by the Florida Department of Children & Families are required to provide a medical statement after being absent for five days in a month.

I agree to provide the center with a written two-week notice of my intent to withdraw my child from the center and to pay all outstanding fees prior to withdrawal. I understand that my failure to do so could result in the withholding of academic records and possible legal action if deemed necessary. Parents will be liable for all collection costs in addition to all outstanding fees including two (2) weeks charge if proper notice is not given.

*I have read this financial agreement and agree to its terms. Furthermore, I understand failure to adhere to this agreement could result in the termination of childcare for my child(ren).*

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Work Number

\_\_\_\_\_  
Date

