

# KinderArt

Inspiring Confident Enthusiastic Learners!

## After School Care

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

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

\_\_\_\_\_ Telephone: \_\_\_\_\_

Days Desired      M    T    W    Th    F

School Attending \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address & Alternative Phone #: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address & Alternative Phone #: \_\_\_\_\_

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

Marital Status of Parents: \_\_\_\_\_

Custody-Visiting Arrangements: \_\_\_\_\_

List Siblings and their Ages:

\_\_\_\_\_

\_\_\_\_\_

Other Members of the Household:

\_\_\_\_\_

Does your child have vision or hearing problems?      Yes    No  
If so, please explain: \_\_\_\_\_

Does your child have any health problems we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies?                              Yes    No  
If so, please explain: \_\_\_\_\_

Are there any special medical, physical or emotional needs that the staff or school  
should be aware of? \_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

- I give KinderArt permission to seek emergency medical care for  
my child, \_\_\_\_\_.
- Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

- I give KinderArt permission to photograph my child, \_\_\_\_\_  
Yes No
- I give KinderArt permission to use my child's photo on the KinderArt website [www.KinderArtKids.com](http://www.KinderArtKids.com) Yes No
- I give KinderArt permission to use my child's photo on KinderArt's Facebook page. Yes No

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

How did you hear about KinderArt? \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Person to be notified in case of emergency:

Mother: \_\_\_\_\_ Home: \_\_\_\_\_  
Work: \_\_\_\_\_ Other: \_\_\_\_\_  
Father: \_\_\_\_\_ Home: \_\_\_\_\_  
Work: \_\_\_\_\_ Other: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Other: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Other: \_\_\_\_\_

## Persons authorized to pick up your child:

Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize KinderArt to seek medical attention for my child, \_\_\_\_\_

Special Considerations: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Emergency Hospital Preference: \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

# KinderArt

## Inspiring Confident Enthusiastic Learners!

### Handbook Sign-off

I have read the KinderArt handbook and agree to follow KinderArt policies which include but are not limited to the following:

intl

- My bill is payable on the 15<sup>th</sup> of each month, beginning with August and ending in April, whether or not a bill is received. I understand there is a 10% late fee assessed to my bill for any payments received after the 20<sup>th</sup>.
- My child will be kept home from school if they are experiencing fever, vomiting or diarrhea, and will remain at home for a full 24 hours after the aforementioned maladies have ceased completely. They will also be kept home for the first 24 hours after beginning an antibiotic.
- KinderArt does not allow peanut or tree nut products on the premises. I agree to refrain from sending such products to school with my child.
- KinderArt does not allow the substitution of non-scheduled days for scheduled days. If I need to send my child on an unscheduled day, I understand there will be a charge for the added day. If I keep my child home for any reason, I understand there will be no deduction for the missed day.
- KinderArt's preschool program ends at 3:30pm, after school care at 5:30pm. I understand that I must have my child picked up and out of the building by the appropriate time. I understand there is a charge of \$2.50 per minute which will be assessed to my bill in the event that my child is picked up late.
- KinderArt requires a thirty day written notice if I wish to withdraw my child from their program. I understand that if proper notice is not given, I forfeit my non-refundable deposit.
- I understand that KinderArt staff are prohibited from babysitting KinderArt students and/or their siblings, and agree not to request such services.
- I understand that if my child is entering the Caterpillar, Butterfly or Bee classrooms, he/she is required to be toilet trained.
- I am aware that KinderArt will send bills electronically. I am also aware that monthly newsletters and activity calendars are available for download from the KinderArt website: [www.kinderartkids.com](http://www.kinderartkids.com).

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Signature

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Date

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## Deposit Record

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

(H) \_\_\_\_\_ (H) \_\_\_\_\_

(W) \_\_\_\_\_ (W) \_\_\_\_\_

(OTHER) \_\_\_\_\_ (OTHER) \_\_\_\_\_

- Background Information Sheet
- Handbook Sign Off
- Permission Slip
- Immunization Form
- Emergency Information Sheet
- Copy of Birth Certificate

.....  
(for office use only)

Class: \_\_\_\_\_

Days Enrolled:    M    T    W    Th    F                    Half                    Full

Deposit Amount: \_\_\_\_\_

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

Check Number: \_\_\_\_\_

Balance: \_\_\_\_\_

School Name & Address:



Health Care Provider Name and Address:

**STATE OF RHODE ISLAND  
SCHOOL PHYSICAL FORM**

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS					
Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis TdaP/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption:  Medical  Religious

Hep B  DTaP  PCV  Polio  Hib  MMR  Varicella  Td/Tdap  Rotavirus  Hep A  Mening  HPV

**PHYSICAL EXAMINATION**

Date of PE \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No  Yes       DIABETES: No  Yes       OTHER: \_\_\_\_\_

Significant Systems Findings: \_\_\_\_\_

ALLERGIES: No  Yes  (Please explain) \_\_\_\_\_ EPINEPHRINE AUTO-INJECTOR REQUIRED: No  Yes

Treatment Plan: \_\_\_\_\_

MEDICATION (REQUIRED AT SCHOOL): No  Yes  (Please list) \_\_\_\_\_

Other medication(s) that may affect behavior or health at school: \_\_\_\_\_

RESTRICTIONS: Can participate in physical education: Fully  With limitation  \_\_\_\_\_

Can participate in sports: Fully  With limitation  \_\_\_\_\_

**LEAD SCREENING (Required for children < 6 years of age only)**  
Student is in compliance with lead screening requirements:  
Yes  No

**SCOLIOSIS SCREENING**  
Yes  No

**VISION SCREENING (Children entering Kindergarten)**  
 Passed screening  
 Screened and referred for comprehensive exam  
 Referred for comprehensive exam, but not screened  
Screening Date: \_\_\_\_\_ Comprehensive Exam Date: \_\_\_\_\_

**TUBERCULOSIS (If required by school district)**  
Date of TB test: \_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_