



Future Einsteins Preschool Program

42 Severance Green
Colchester, VT 05446
802-288-9035

143 Windridge
Williston, VT 05495
802-662-4751

29 George Hill Rd
Johnson, VT 05656
802-635-2400

What we need when your family joins our center

Parent/Guardian Information

Parent or Guardian Name _____

_____ **Completed Enrollment Forms**

_____ **\$50 Deposit**

_____ **Subsidy Certificate (if qualified)**

_____ **Up to date Immunization Record**

_____ **At least one change of clothes**

_____ **Appropriate clothing for going outside (e.g., sneakers, boots, jacket, hat, etc.)**

_____ **Rest Time Items: Blanket, Sheet, Stuffed Animal (if applicable), etc.**

Future Einsteins Center Staff Information

Completed by _____



Future Einsteins

Colchester (802)288-9035

Williston (802)662-4751

Johnson (802)635-2400

Child Information Form

Child's Name _____

Child's Nickname _____

Known Food Allergies: _____

Important: Please ensure _____

your child's teacher knows

of any life threatening allergies. _____

Prior Childcare Experience _____

Daily Routine _____

Sleeping Habits _____

Child's Fears _____

**Anything else you would
like us to know about your
child?** _____

Parent or Legal Guardian's Signature: _____

Date: _____

Enrollment Form

Check Location Applying For:

___ Colchester Location, 42 Severance Green, Colchester, VT 05446

___ Williston Location, 143 Windridge, Williston, VT 05495

___ Johnson Location, 29 George Hill Road, Johnson, VT 05656

Child's Information

Child's Name: _____

Child's Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Parent or Guardian Information

Parent/Guardian Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Work # _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Parent or Guardian Information

Parent/Guardian Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Work # _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Continue on next page

Child's Information

Child's Name: _____

Child's Date of Birth: _____ Date of Enrollment: _____

Child's Schedule(After Care for 3:30-5:30 is just \$10 per day/\$50 per week)

Monday	Tuesday	Wednesday	Thursday	Friday
Start/End Time	Start/End Time	Start/End Time	Start/End Time	Start/End Time

Preschool Rates (Choose One) without Act 166 Funding

8:00am-3:30pm (AS \$10/day) ___ 5 Day Rate \$250/week/child ___ 4 Day Rate \$213/week/child ___ 3 Day Rate \$180/week/child	8:00am-1:00pm ___ 2 Day Rate \$142/week/child	8:00am-11:00am ___ 5 Day Rate \$151/week/child ___ 4 Day Rate \$128/week/child ___ 3 Day Rate \$100.50/week/child
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Preschool Rates (Choose One) with Act 166 Funding

8:00am-3:30pm (AS \$10/day) ___ 5 Day Rate \$146/week/child ___ 4 Day Rate \$109/week/child ___ 3 Day Rate \$76/week/child	8:00am-1:00pm ___ 2 Day Rate FREE week/child Choose Days: ___ Mon/Tues ___ Tue/Thu	8:00am-11:00am ___ 5 Day Rate \$47/week/child ___ 4 Day Rate \$24/week/child ___ 3 Day Rate Free /week/child
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Agreement

I understand that I am contracting for the above time slot and I agree to abide by the terms and conditions noted below as well as those indicated in the Future Einsteins Parent's Handbook.

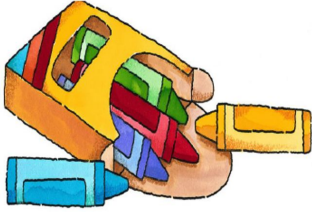
- * A nonrefundable deposit of \$50 is due prior to enrollment in the preschool. This deposit will hold your child's spot in the center for up to one week and will be applied towards your first week of school. Holding a spot longer than two weeks and the fees required for this will be at our discretion.
- * Weekly payments of the contract fee indicated above for full-time (5 day or 4 day program) preschoolers are due in advance on the Friday prior to the week of service. Monthly payments of the contract fee indicated above for part-time (3 day program) are due on the first Monday of each month. Payments are due regardless of school closings/vacations/Covid related closures, etc.
- * If the tuition payment is late but paid during the week of service, the late fee will be \$5.00 for each day that the payment late (except for extenuating circumstances which will be determined on a case by case basis).
- * If the tuition payment is more than 3 days late, Future Einsteins has the option to cancel service; however you would still be required to pay any tuition and late fees owed.
- * If the bank returns a check, the parent/guardian is charged both the late fee and a \$35 return check fee. If payment for contracted care is not received, and no arrangement for payment has been made, Future Einsteins has the option to cancel service; however, you would still be required to pay any tuition and fees owed. Preferred method of payment is a credit card that we will keep on file to charge our parents on a weekly/monthly basis.

Authorization

I agree to the terms and conditions noted above and I have read and agree to abide by the terms and conditions stated in the parent's handbook. By signing this document, I am confirming that I have read, understand, and agree to follow the terms and conditions while my child attends Future Einsteins. Future Einsteins reserves the right to cancel this contract if its policies are not upheld.

Parent or Legal Guardian's Signature: _____ Date: _____

Future Einsteins Authorized Signature: _____ Date: _____



Future Einsteins
42 Severance Green
Unit 105
Colchester, VT 05446
802-288-9035

Automatic Billing Authorization Form

Monthly Charge: _____ Weekly Charge: _____

Primary Card Account

Secondary Card Account

Name on credit card (exactly as printed)

Name on credit card (exactly as printed)

Billing Address for credit card (Street Apt#)

Billing Address for credit card (Street Apt#)

_____/_____/_____
City State Zip Code

_____/_____/_____
City State Zip Code

_____/_____
Credit Card Number Expiration Date

_____/_____
Credit Card Number Expiration Date

CCV Code

CCV Code

_____/_____
Signature Today's Date

_____/_____
Signature Today's Date

***This authorization is valid until I provide you with written cancellation.**

Children's Name(s) _____



Future Einsteins
Colchester/Williston/Johnson
Phone: C-(802)288-9035
W-(802)662-4751
J-(802)635-2400

Emergency Release Form

Emergency Information

Child's Name: _____

Child's Doctor _____ Phone _____

Child's Dentist _____ Phone _____

Child's Insurance Information

Health Insurance Company: _____ Policy # _____

Dental Insurance Company: _____ Policy # _____

Parent or Guardian Information

Parent/Guardian Name _____

Work/Cell Phone _____ Home Phone _____

Parent/Guardian Name _____

Work/Cell Phone _____ Home Phone _____

Authorization

I _____ and/or _____ understand the above and hereby authorize any member of the staff at Future Einsteins to give permission for any medical, medical transportation, hospital, or dental treatment for child _____ in the event of injury or illness, while the child is in the care of the above named provider or center. I understand and agree that I would be financially responsible for any medical, hospital, or dental treatments unless my child's injury is due to improper supervision or faulty equipment. I have full understanding that every attempt will be made to contact the parent/guardian in the event medical, hospital, or dental treatment is necessary. I understand that certain medical emergencies may not allow much time for contact of a parent/guardian and that if a life threatening situation arises, immediate medical attention will be sought by the provider/center. Medical transport is allowed, if needed.

Parent or Legal Guardian's Signature: _____ Date: _____

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Photo Release Form

Child's Information

Child's Name: _____

Photo Release

Please check the appropriate box

I **give permission** to Future Einsteins to take or have photos take of my child. I understand that these photos will not be sold or distributed without my knowledge or permission.

I **do not give permission** to Future Einsteins to take photos of my child.

Please check the appropriate box

I **give permission** to Future Einsteins to videotape or have videotapes taken of my child. I understand that these videotapes will not be sold or distributed without my knowledge or permission.

I **do not give permission** to Future Einsteins to videotape or have videotapes taken of my child.

Please check the appropriate box

I **give permission** to Future Einsteins to include photographs of my children on marketing materials and/or on the www.futureeinsteinsvt.weebly.com web site. I understand that my child's name will not be used on the web site or on the marketing materials.

I **do not give permission** to Future Einsteins to include photographs of my children on marketing materials and/or on the www.futureeinsteinsvt.weebly.com web site.

Authorization

By signing this document, I am confirming my choice to either grant or deny the photographing or videotaping of my children while they are enrolled and attending Future Einsteins

Parent or Legal Guardian's Signature: _____ Date: _____

Future Einsteins Authorized Signature: _____ Date: _____

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Emergency Contact Information

If one of the above parents or guardians cannot be reached in an emergency or illness, please contact one of the following individuals. **The State of Vermont requires that we have on file, the current names and daytime phone numbers of at least two individuals that can pick up your child if we cannot reach you.**

The following people have permission to pick up my/our child without written notification.

Emergency Contact Person

Emergency Contact's Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact Person

Emergency Contact's Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Authorization

Parent or Legal Guardian's Signature: _____

Date: _____



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To be filled out by health care provider

CHILD CARE GENERAL HEALTH EXAMINATION FORM

Child's Name: _____

Date of Birth: _____ Date of Last Exam: _____

_____ This child has no health conditions or medications that impact enrollment in child care.

_____ This child has a condition or medication that should be known by the child care provider.

Health Care Provider Name: _____

Phone Number: _____

Health Care Provider Signature: _____

Date: _____