

Mother's Morning Out Registration 2017-2018



Welcome to Mom's Morning Out! This program is specifically designed for the child who is 18 months old (by 9/1/2017) through 24 months old. We hope that this experience will be fun for your child and a well-deserved break for you. Registration for current families begins the week of January 24, 2017. On January 31, 2017, registration will open to the community.

Mother's Morning Out classes are on Tuesdays, Wednesdays, and Thursdays. Class size is limited to eight children. You will be advised as soon as possible if there is a problem with the day of the week you have selected. There is no helper responsibilities associated with this program and the costs are as follows:

Mother's Morning Out--Rates and Fees

1 day per week tuition:	\$ 85.00 per month (9 monthly payments from September 2017-May 2018)
2 days per week tuition:	\$170.00 per month (9 monthly payments from September 2017-May 2018)

Payment Methods: MasterCard, Visa, Cash, or Check (payable to Northland)

Registration Fee for 1 day class (non-refundable)	\$ 50.00 per child due at Registration
Annual Materials Fee for 1 day class	\$ 50.00 per child due at 8/22/2017
Registration Fee for 2 day class (non-refundable)	\$100.00 per child due at Registration
Annual Materials Fee for 2 day class	\$ 75.00 per child due at 8/22/2017

In addition, each child must have the following on file:

- Health Form (Form 3040)*
- Immunization Record (Form 680)*

*Your pediatrician's office will provide you with copies of these forms. You may submit them any time before the first day of school in August.

The Cooperative School at Northland admits all children regardless of race, color, national or ethnic origin and reserves the right to limit the days your child attends based on enrollment. If you have any questions, do not hesitate to contact Pam Anderson at 407-949-7179 or via email at pam.anderson@northlandchurch.net

Mother's Morning Out Student Information 2017-2018



Child's full name _____ Name Preferred at School _____ Birthdate _____

Full Address _____ Email: _____

Mother's name _____ Cell _____ Work _____ Other _____

Father's name _____ Cell _____ Work _____ Other _____

Child lives with: Both Parents _____ Mom only _____ Dad only _____ Grandparents _____ Other _____

Anything we need to know about living situation: _____

Weekday(s) preferred Tuesday _____ Wednesday _____ Thursday _____

Please check all that apply

Name	Phone	Relationship to Child	Emergency	Pick Up
1.				
2.				
3.				

Does your child have any allergies? If so, to what substances and how are they manifested? _____

Please provide any additional information which you think might be important for us to have concerning your child (fears, health issues, family situations, etc.).

Parent Initials

_____ I have read *Know Your Child Care Facility*
(Available in the school office or online at www.myfamilies.com/childcare → For Families)

_____ I give my child permission to participate in any food related activity special occasion/learning activity) that includes food consumption

OR

_____ I **DO NOT** give my child permission to participate in any food related activity special occasion/learning activity) that includes food consumption

_____ (Parent Signature) _____ (Date)

For Office Use: Reg _____ MR _____ 3040 _____ 680 _____



AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Please fill out one for each child you enroll.

Child's Name: _____ Date of Birth ___/___/___ SEX: M ___ F ___

Parent/Guardian Name(s): _____

Full Address: _____

Phone: _____
(Mother cell) (Father Cell) (Other)

Child's Physician: _____

Physician Address and Phone: _____

Insurance Company Name: _____

Address: _____ Telephone: _____

Policy No.: _____ Medicaid No.: _____

ALLERGIES: _____

I _____, hereby give my consent the Cooperative School at Northland to take my child, _____ to the nearest hospital during the hours of preschool, 9:00 a.m. – 1:00 p.m. and hereby release Northland, a Church Distributed and the Cooperative School at Northland from any and all liability, as a result of any negligent medical emergency treatment. I will assume full responsibility for any and all expenses incurred (i.e. Ambulance, medical and /or hospital fees, etc.)

Signature: _____ (In the presence of a notary)

Date: _____

STATE OF FLORIDA)

)

COUNTY OF _____)

On this the _____ day of _____, 20____, before me, _____, the undersigned officer, personally appeared _____, known to me to be the person whose name is subscribed to the within instrument and acknowledged that she/he executed the same for the purpose therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

Notary Public

My commission expires: _____