ALL ABOUT SPANISH
Language Center

1894 Newbridge Road,
Bellmore, New York 11710
(516) 462-7777
www.AllAboutSpanish.org
info@allaboutspanish.org

2018-2019 EARLY CHILDHOOD PROGRAM Enrollment Form

"Please submit enrollment form with a Non-Refundable $75 Registration Fee"

	STUDENT 1		STUDENT 2		STUDENT 3		STUDENT 4	
FIRST NAME								
LAST NAME								
BIRTHDAY								
GENDER	Male/Female		Male/Female		Male/Female		Male/Female	
AGE ON September 1st	Yrs.	Months	Yrs.	Months	Yrs.	Months	Yrs.	Months
GRADE AS OF SEPT. 2017								
FAMILY EMAIL								

Address Town Zip Home Phone#

Mother's Name Cell Phone# Work Phone# Occupation

Father's Name Cell Phone# Work Phone# Occupation

Emergency Contact/ Other than parent Phone# Relationship to Child:

Names and ages of siblings:_____

Has your child attended a preschool, daycare or playgroup? Yes No

If yes, please provide name of school or daycare_____

What are your child's interests?_____

What languages other than English are spoken at home?_____

Does your child have any behavioral challenges? _____

Is your child currently receiving services currently? Yes__No

If yes, please explain: _____

Is there anything else you would like us to know about your child?_____

Is your child toilet trained? ____Yes_____No (Please Check One)

Are you willing to have your child's name, address, telephone number and birthday added to our class list which will be distributed to all parents in your child's class? ____Yes_____No (Please Check One)

Would like your child to be able to participate in pictures and videos to share with our families in our Private Twitter Account for Classrooms ONLY. ____Yes_____No (Please Check One)

Would like your child to be able to participate in pictures and videos for Publicity Purposes (Website/Newsletter/Newspaper/Social Media.)____Yes_____No (Please Check One)

Health History & Emergency Information:

Health Problems, Allergies, or other important information: Please list any allergies, health concerns, or other important information we should know about your child. Students who require (EPI-PEN,) Benadryl, asthma inhalers or nebulizers to prevent life-threatening conditions must contact the program Director understand the severity of any condition and establish an INDIVIDUAL CARE PLAN prior to start of SCHOOL:

Allergies:_____ Special Medical Conditions:_____

Medications:_____ Other: _____

Physician:_____ Dentist:_____

Parent/Guardian Emergency Contact Information:

Name:_____ Address:_____

E-Mail Address:_____

Telephone: Home#(_____)_____Cell# (_____)_____Work#(____)_____

My child may be released to:

Name:_____ Phone.# (_____)_____

Name:_____ Phone.# (_____)_____

Name:_____ Phone.# (_____)_____

How did you hear about AAS? (PLEASE CHECK ALL THAT APPLY)

☐ Family/Friend/Teacher Referral ☐Flyer/Postcard Mailer

☐ Walked/Drove By ☐ Yelp

☐ Online (Google search, etc.) ☐ Groupon

☐ Fundraiser/Community Event ☐ Newspaper Ad

☐ Facebook/Instagram/Twitter/Social Media ☐ Other:_____

If you were referred by an AAS family, please list them here (one family only):_____

EARLY CHILDHOOD PROGRAM: 09/11/18-06/14/19

<table>
<tr><td colspan="2">2 YEAR OLD PROGRAM
MORNING SESSION 9:15-11:45 AM
AFTERNOON SESSION 1:00-3:30 PM
(Child Must be Two by December 1, 2018)</td></tr>
<tr><td colspan="2">2 DAYS (T/TH) $2530_____AM_____PM____</td></tr>
<tr><td>3 YEAR-OLD PROGRAM
MORNING SESSION 9:15AM-12:00PM
AFTERNOON SESSION 1:00-3:45PM (T/TH ONLY)
(Child Must be Three by December 1, 2018)
Child must be toilet-trained.</td><td>4 YEAR-OLD PROGRAM
MORNING SESSION 9:15AM-12:00PM
AFTERNOON SESSION 1:00-3:45PM (T/TH ONLY)
(Child Must be Four by December 1, 2018)
Child must be toilet-trained.</td></tr>
<tr><td>2 DAYS (T/TH) $2630____AM____PM____
3 DAYS (M/W/F) $3670____AM____
5 DAYS (M-F) $4556____AM____</td><td>2 DAYS (T/TH) $2630____AM____PM____
3 DAYS (M/W/F) $3670____AM____
5 DAYS (M-F) $4556____AM____</td></tr>
</table>

All About Spanish's Language Center POLICIES & PROCEDURES

Physical and Immunization Requirements

_____New York State requires that each child entering an Early Childhood Pre-School Program must show proof of having received a new physical examination as well as all required immunizations. The physical must be current and dated within one year prior to the date of entrance. In addition, immunizations are required for admission to school and a child may not be permitted to enter school if immunization requirements are not met.

Tuition is Annual:

_____Tuition is an annual fee that is divided into 10 equal payments. Tuition payment #1 is due August 1st. If registration takes place after this date, tuition payment #1 is due at the same time as the registration fee. Subsequent Tuition payments (2 -10) are collected via electronic payment on the 1st or 15th.

Registration Fee:

_____Registration fee is annual (September-June) and is a non-refundable fee that must be submitted with enrollment form.

Tuition:

_____All payments are processed by pre-authorized CREDIT CARDS on the 1st or 15th of the month. 2 Year Old Program: Each payment for the 2 year olds (2 days/wk) is $2,530 (Annual/ $253 per payment.) 3 & 4 Year Old Program: Each payment for the 3 & 4 year olds (2 days/wk) is $2630 (Annual/$263 per payment), (3 days/wk) is $ 3670 (Annual/$367 per payment) and (5 days/wk) is $4556 (Annual/$455 per payment.) Tuition is **NEVER PRO-RATED** or **REDUCED** for ABSENCES, SICKNESS, VACATIONS and program closings due to INCLEMENT WEATHER.

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Withdrawal

_____Class space is reserved for each student. If you withdraw your child during the school year, there will be a CHARGE for classes ATTENDED or UNATTENDED up to 30 days AFTER a written withdrawal letter is given to AAS indicating date of notice and the last date your child will attend our program. Please note that "30-days" represents 4 weeks tuition.

Make-Ups

_____Only 2 Missed classes per year per student are allowed, but ONLY upon availability and within our **EARLY CHILDHOOD PROGRAM ONLY**. If a make up is missed, there is NO rescheduled make-up. TWO Snow-Day make-up days will be offer for program closings due to INCLEMENT WEATHER (See calendar for dates.)

Conduct

_____For the safety and general welfare of all students, ALL ABOUT SPANISH reserves the unrestricted right to remove a student whose conduct or influence, in the opinion of the director, is inimical to the best interest of the program.

Late Pick-Up Notice

_____Due to our licensing restrictions and to comply with Nassau County Office of Children & Family Services Policy, we have a **VERY STRICT PICK-UP/DROP OFF POLICY**. Children are not to be dropped off before 9:15 am or picked up after 11:45 am (2 year old program) and 12:00 pm (3-4 year old AM program) & 3:45 pm (3-4 year old PM program.) Please be considerate of our staff in following the program times, with the exception of an extreme emergency. If a parent or authorized adult will be late, it is their responsibility to notify the office as soon as possible.

Injuries

_____Parents, legal guardians of minors, students and adult students waive the right to any legal action for any injury sustained on AAS property resulting from normal activity or any other activity conducted by the students during school time. All About Spanish is NOT RESPONSIBLE for any damage done to vehicles.

Medications

_____**NO MEDICATIONS** will be given at our program. We should be notified immediately if the child develops a contagious disease. The staff will also be alert to any of the symptoms noted above. If any symptoms are observed the child's parent and/or caregiver will be notified to come to the school. The child will be removed from the classroom and wait at the Front desk of the school with a Teacher Assistant until a parent and/or caregiver arrives.

Permission to Receive Emergency Medical Care

_____Should a child suffer an injury or illness while in the care of All About Spanish, and the program cannot reach a parent/care giver phone immediately, All About Spanish has permission to secure medical attention and care for the student as may be necessary and will not assume responsibility for the payment of medical fees or expenses incurred.

Emergency Information

_____Emergency Contact Information must be on file with the school by the first day of school. Parents must indicate the best way to reach them in case of an illness or accident during the school day. Three emergency contacts need to be included. Emergency contacts must be local and able to reach the school in a timely fashion (approximately 15 minutes after a call.)

AUTHORIZATION AGREEMENT FOR ACH PAYMENTS

(I) do hereby authorize the ALL ABOUT SPANISH Inc., hereinafter named the (COMPANY), to initiate recurring (debit or credit) entries to my (CREDIT CARD ACCOUNT) as indicates and named below as the depository financial institutions, hereafter named (FINANCIAL INSTITUTION). (I) Acknowledge that the origination of ACH transactions to (my) account must comply with the provisions of U.S. Law. Furthermore, if any such debits should be returned NSF, (I) authorize the COMPANY to collect such debits by electronic debit and subsequently collect a returned debit NSF fee of $25 per item by electronic debit from my account identified below, and authorize all the above as evidenced by my signature below.

DISCOUNT OPTIONS

☐Sibling Discount: 2nd child 10% off lesser tuition
☐Sibling Discount: 3rd child 15% off lesser tuition
☐Sibling Discount: 4th child 20% off lesser tuition
☐Police/Fire/Military Discount: 10% discount for children of Police Officers, Fire Fighters, and Military Personnel
☐Early Bird Discount: 10% discount for students enrolled by 02/15/18
☐Total Payment Discount (cash or check only): -5% discount is applied to all accounts paid in full by September 1.
☐Two Payment Discount (cash or check only): 3% tuition discount is applied when tuition is paid in 2 payments; 1/2 payment by September 1st and 1/2 payment by February 1st.

Only ONE discount can be applied per STUDENT and CANNOT be COMBINED with any other OFFER

First Month's Tuition:_____

Total first month's charge:_____Date:_____Please write your initials here approving charges:_____

☐ Monthly on the 1st ☐Monthly on the 15th

Continues payments start date:_____end date: _____Payment amount:_____(Monthly)

"Payments are recurring and are deducted on the first of each month until the end date or withdrawal is requested."

_____AUTO DRAFT FROM CREDIT CARD OR DEBIT CARD

MC_____ VISA_____ AMERICAN EXPRESS_____ DISCOVER_____

Name of Cardholder:_____ Account Number:_____

Exp. Date:_____ CVV: _____

It is understood that All About Spanish Language Center reserves the right to terminate this agreement at any time if these financial obligations are not met.
This authorization is to remain in full force and effect until the end date of this agreement or the COMPANY has received a WITHDRAWAL written notification (SEE WITHDRAWAL AGREEMENT) from me of its termination in such time and in such manner as to afford the COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.
It is agreed that any dispute concerning, relating, arising out of or referring to the subject matter of this contract shall be resolved exclusively by binding arbitration in Nassau County, New York according to the then existing commercial rules of the American Arbitration Association and the substantive laws of that state.

I have read and agree to abide by the policies listed above and I hereby represent that I have full authority to sign this enrollment agreement and will be responsible for payments of all fees.

Name:_____ **Signature of Parent/Guardian:**_____ **Date:**_____

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STUDENT HEALTH REPORT

1. THIS PART TO BE COMPLETED BY PARENT (Please use back if necessary)

Authorization: In the event I cannot be reached, I hereby give permission to the physician or hospital selected by Merrick Woods to secure proper treatment for my child in case of accident or sudden illness.

Date_____ Parent's signature_____

Name of Child _____ Date of Birth _____ / _____ / _____

Address _____Home Phone #_____

Father_____Work#_____Cell#_____

Mother_____Work#_____Cell#_____

Physician_____Phone#_____

Emergency Contact (other than parents) _____Phone#_____

Personal History: (Significant illnesses, serious accidents, handicapping conditions)

Allergies: (foods, insect bites, medical, plants)

Medication taken regularly: (specify drug and condition)

Any other information you feel would help us in regard to your child's adjustment:

2. PHYSICAL EXAMINATION - TO BE COMPLETED BY PHYSICIAN

Date of Examination _____

Hearing Exam Results:_____ Vision Exam Results:_____

Recommendations for Activities: Full physical activity YES _____ NO _____

Specific physical activities contraindicated _____

Restrictions regarding diet or medication _____

Pertinent abnormal findings _____

3. CERTIFICATE OF IMMUNIZATION

In accordance with New York State Public Health Law 2164 a Certificate of Immunization, signed by a physician, listing exact dates, must be on file the first day of school. **Students will not be admitted to school if immunization requirements are not met.**

Which of the following has the participant had?

□Measles
□Mumps
□Rubella
□Chicken Pox
□Hepatitis A
□Hepatitis B
□Hepatitis C

TB Mantoux Test:
Date of last test ___/___ /___
Result: Positive Negative
_____mm

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP	_____	_____	_____	_____	_____	_____
Hep. A	_____	_____	_____	_____	_____	_____
EIP V	_____	_____	_____	_____	_____	
MMR	_____	_____				
Measles	_____	_____				
Mumps	_____	_____				
Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitus B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				
Pneumococcal (PCV)	_____	_____	_____	_____		

Lead Screening (include all dates and results)

1 Year ___/___ /___ Result: _____mcg/dL □Venous □Capillary
2 Year ___/___ /___ Result: _____mcg/dL □Venous □Capillary
Most recent: ___/___ /___ Result: _____mcg/dL □Venous □Capillary

Legal requirements for immunizations waived because of:

_____ Religious Exemptions - N.Y.S. Dept. of Education document
_____ Physician's Medical Exemption - Physician's statement attached
_____ Vaccine(s) Waived: _____
_____ Vaccines waived due to temporary condition _____ Yes _____No
If yes, date scheduled for immunization _____/_____/_____

_____ ____/_____/ _____

Signature of Physician Date Physician should affix stamp