

For Office Use Only: Method of Payment
 ___ Check Check #: _____
 ___ Credit Card Cash:\$ _____
 ___ M.O.#: _____

**2008 - 2009
 Kaleidoscope Corner
 PAYMENT AGREEMENT**

Childcare Site (Please PRINT)

Parent Name (Please PRINT)

Start Date

Child's Name (Please PRINT)	Early Risers					Kadoodles/LB AM PM					After School					Amount
	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	*F	
1)																
2)																
3)																
4)																

***Roberts K-8, Odyssey Charter early release Friday add'l (1-3 pm \$22/mth; Friday only 1-6pm \$88/mth)**

Non-Refundable Deposit Fee

- \$60 for one child
- \$75 for more than one child
- \$25 reinstatement fee
- \$15/per child CAMPS ONLY**

SUBTOTAL			
DISCOUNT:	25%	15%	10%
MONTHLY TUITION PAYMENT			

Available Discounts (Only one discount will apply per family. Multiple discounts will not be allowed)

I understand that the fifteen or twenty-five percent discount will not be applied to my account until the Kaleidoscope Corner Financial Office has received my income verification within 30 days of today's date, and determined my eligibility.

Required Paperwork for 15% or 25% Discount:

- Last year's income tax return
- Two most recent paycheck stubs
- A 10% discount to families when their *monthly tuition exceeds \$350. OR*
- A 15% discount to families who are income eligible. **OR**
- A 25% discount to families who are income eligible.
-

Human Services

If you are a CCAP recipient, you must present written authorization from your Aspen Family Service caseworker for the current school year and site location at the time of registration. If you do not have written authorization **you will be responsible for all tuition charges and deposits at the time of registration.**

 Parent Initials required

_____ *I believe I am eligible for Human Services child care reimbursement (CCAP) and would like to be contacted for a pre-screening or authorization update meeting sponsored through our department*

CREDIT CARD PAYMENT OPTIONS

(Visa or MasterCard only)

_____ **(Tuition Express form required)**

_____ Please charge my credit card **one time only** (please check one):

_____ Registration fee

_____ Registration fee and current tuition payment

Credit Card #: _____ Exp. Date: _____ CVV# _____

Signature: _____

(Please read and sign page 2 of your Payment Agreement to complete)

Schedule of Payments:

Payment	Tuition Express Due Date	Due Date	Coverage Period
1 of 9	August 1, 2008	August 20, 2008	August 18 – September 22, 2008
2 of 9	September 2, 2008	September 20, 2008	September 23 – October 17, 2008
3 of 9	October 1, 2008	October 20, 2008	October 18 – November 22, 2008
4 of 9	November 3, 2008	November 20, 2008	November 23 – December 17, 2008
5 of 9	December 1, 2008	December 20, 2008	December 18 – January 22, 2009
6 of 9	January 5, 2009	January 20, 2009	January 23 – February 17, 2009
7 of 9	February 2, 2009	February 20, 2009	February 18, March 22, 2009
8 of 9	March 2, 2009	March 20, 2009	March 23 – April 17, 2009
9 of 9	April 1, 2009	April 20, 2009	April 18 – May 28, 2009

Terms of Payment Agreement *(Please read and initial that you have read and agree to each of the following):*

_____ I understand that Kaleidoscope Corner will make every effort to send invoices by the 3rd business day of each month. However, it is my responsibility to pay the monthly expense by the 20th of each month.

_____ I understand that if my payment is not received by the 25th of the month, a \$25 *non-reversible* late fee will be assessed to my account.

_____ I understand if payment is still not received by the 30th of the month, my enrollment will be terminated.

_____ I understand that if my child arrives at Kaleidoscope Corner following disenrollment due to an unpaid balance, he/she will be taken to the school office, and I will be contacted to pick up my child.

_____ I understand that if my child is disenrolled due to an unpaid balance, my child may be reinstated provided my account balance has been paid in full. If there is a waiting list for that site my child will be placed on the bottom of the list, and I will be notified when space is available. I also understand that my account will be assessed a \$25 reinstatement fee and there will be a two-day waiting period for my child to return.

_____ I understand that I, the signer of this document, am fully responsible for payment. Kaleidoscope Corner will not process split billing between two parents or guardians.

_____ I understand that to withdraw from the program or to change my child's schedule, I must complete the proper forms *two days in advance*. Failure to do so will result in my account being charged full price for that month.

_____ I understand that credits or refunds are **NOT** issued for unused days.

_____ I understand that a \$30 administrative fee will be assessed for returned checks. *After one returned check, payment must be made with cash or money order.*

_____ I understand that if I am applying for the 15% or 25% discount, I must submit my paperwork within 30-days of today's date, as stated on the signature line. Furthermore, I understand that if the Financial Office has verified my eligibility, I agree to notify them within 30-days if my financial situation has changed.

Parent/Guardian Signature _____ Date _____

Social Security Number *(Optional)* _____

Staff Signature _____ Date _____

KALEIDOSCOPE CORNER Information Card

Parent/Guardian Information

Registration Start Date: _____

Child lives with: (Check one or more) Mother Father Other (Please Specify) _____

Mother/Guardian First Name: _____ M.I. _____ Last Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell/Pager: _____

Employed By: _____ Address : _____ City/State/Zip _____

Office Phone: _____ Email _____

Authorized to pick up Not able to pick

Father/Guardian First Name: _____ M.I. _____ Last Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell/Pager: _____

Employed By: _____ Address : _____ City/State/Zip _____

Office Phone: _____ Email _____

Child Information

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Gender: Male Female Age _____

Ethnic group you consider the child to be a member of _____ (needed for Federal Food Program)

School Child Attends _____ KC Site: _____

If the school the child attends is different than the Kaleidoscope Corner Site, you must complete a bus arrival/departure form.

Allergies Yes/No Medical Problems Yes/No Asthma Yes/No Dietary Needs Yes/No Other Yes/No

Please Explain: _____

PERSONS WHO ARE AUTHORIZED TO PICK UP MY CHILD AND WHOM KALEIDOSCOPE CORNER MAY CONTACT IN THE EVENT OF AN EMERGENCY IF PARENT(S) OR GUARDIAN(S) CANNOT BE REACHED.

Other Emergency Contact Information Order of Emergency Contact 1 2 3 (check only one)

Name of Emergency Contact: _____ Relationship to Child: _____

Home Address: _____ City/State/Zip _____

Home Phone: _____ Work Phone _____ Cell/Pager# _____

Able to pick up Not able to pick up

Other Emergency Contact Information Order of Emergency Contact 1 2 3 (check only one)

Name of Emergency Contact: _____ Relationship to Child: _____

Home Address: _____ City/State/Zip _____

Home Phone: _____ Work Phone _____ Cell/Pager# _____

Able to pick up Not able to pick up

Other Emergency Contact Information Order of Emergency Contact 1 2 3 (check only one)

Name of Emergency Contact: _____ Relationship to Child: _____

Home Address: _____ City/State/Zip _____

Home Phone: _____ Work Phone _____ Cell/Pager# _____

Able to pick up Not able to pick up

Parent/Guardian Signature: _____ Date: _____

SPECIAL NEEDS INFORMATION

Has your child been identified as disabled? No Yes

If yes, what special accommodations or modifications are needed?

*Does your child receive special education services? No Yes

Check any of the following that apply to your child.

- Learning Disabilities Speech/Language Vision
 Behavioral Disorders Physical Therapy Hearing

***If my child has a disability, I will need to have a meeting with the site Program Specialist before he/she may begin the program.**

Please Specify _____

If either "Yes" has been checked, please refer to the Special Needs Policy in your Parent Handbook

Are there any activities your child cannot participate in due to physical, social or religious reasons? No Yes

(If yes, please specify)

Personal Release Statement: I understand that there is risk of injury in any recreational or sport activity and I voluntarily assume such risk. I take full responsibility for the actions and physical condition of my child. I agree to indemnify and hold harmless the Department of Community Education and Denver Public Schools from liability, loss, cost or expense (including attorney's fees, medical, dental and ambulance costs) that my child may incur while participating in Kaleidoscope Corner activities.

Parent's Initials _____

IMMUNIZATION/HOSPITAL INFORMATION

My child's immunization record and health information is on file at the school and I authorize Kaleidoscope Corner to access it.

Parent's Initials _____

Doctor's Name _____

Dentist's Name _____

Business Phone _____

Business Phone _____

Address _____ City/State/Zip _____

Address _____ City/State/Zip _____

Preferred Hospital: (Please mark one)

___ Denver Health Medical Center, 777 Bannock St. Denver CO 80204 Phone: 303-436-6000

___ Presbyterian/St. Luke's Medical Center (PSL), 1719 E. 19th Ave., Denver, CO 80218 Phone: 303-839-6000

___ The Children's Hospital, 13123 E. 16th Ave., Aurora CO 80045 Phone: 303-861-8888

___ Rose Medical Center, 4567 E 9th Ave., Denver, CO 80220 Phone: 303-320-2121

___ Porter Adventist Hospital, 2525 Downing St., Denver CO 80205 Phone: 303-778-1955

___ St. Joseph's Hospital, 1835 Franklin St., Denver, CO 80218 Phone: 303-866-8600

___ University of Colorado Hospital, Anschutz Campus, 12605 E 16th Ave. Aurora, CO 80045 Phone: 303-372-0000

___ Name, Address and Phone # of preferred Hospital (if not listed): _____

I do hereby authorize the above named physician to render such treatment as may be deemed necessary in an emergency for the health of the child. In the event that a parent/guardian, or alternate person named on this form cannot be reached, or if the name of a doctor, dentist or hospital has not been provided, the staff is hereby authorized to call 911 for medical assistance. The staff is also authorized to take whatever action is deemed necessary in their judgment for the health of the aforementioned child.

Parent Signature _____

Date _____

Movie/Media Authorization SIGN IN/OUT AUTHORIZATION

I do do not give permission for my child to appear in any media coverage approved by Kaleidoscope Corner.

I give permission for my child to view G Movies PG Movies No Movies

I understand that Kaleidoscope Corner is not responsible for children that walk or bus to the program site until they are signed in. Furthermore, I understand that Kaleidoscope Corner is not responsible for children that walk or bus from the program site once they are signed out.

I give permission for my child to sign him/herself in to Early Riser Kadoodles After School

I give permission for my child to sign him/herself out of Kadoodles After School Release Time _____

My child may not leave by her/himself. _____ (initials)

In accordance with my decision to register this child in Kaleidoscope Corner, I hereby acknowledge that I have received a copy of the Parent Handbook and agree to abide by the policies and procedures outlined therein.

Parent/Guardian Signature _____

Date _____

Kaleidoscope Corner
School-Age child care
Sunscreen Form

Child's Name: _____

- ☺ Children over 4 years of age must apply sunscreen to themselves under direct supervision of a staff member. Kaleidoscope Corner staff **will not** apply sunscreen to your child(ren).
- ☺ Children who are under 3 years of age Kaleidoscope Corner staff **will be** responsible for applying sunscreen.
- ☺ Kaleidoscope Corner staff **will be** responsible for reminding your child(ren) to apply sunscreen prior to outdoor activities.
- ☺ Parents are encouraged to provide sunscreen for their child(ren).
- ☺ Sunscreen must be clearly labeled with child's name to ensure safety.
- ☺ Kaleidoscope Corner **will not** provide sunscreen to the Kaleidoscope Corner children.

_____ **YES**, I agree to the above guidelines regarding sunscreen. I authorize my child(ren) over 4 years of age to apply sunscreen to themselves while at Kaleidoscope Corner. I understand that the sunscreen I provide must be labeled with my child(ren)'s name.

_____ **YES**, I agree to the above guidelines regarding sunscreen. I authorize Kaleidoscope Corner staff to apply sunscreen to my child who is under the age of 3. I understand that the sunscreen I provide must be labeled with my child(ren)'s name.

Listed below are any necessary instructions regarding sunscreen application for my child:

Parent/Guardian Signature

Date