Dear Parents/Guardians,

Welcome to the Kearns-Saint Ann Early Childhood Center and the Kearns-Saint Ann Catholic School community! The enclosed packet of information must be completed and given to the Director prior to starting in our center. In the packet you will find our parent handbook and contract, emergency contact form, medical release form, automatic-withdrawal and agreement to pay form, and photography/video release form. Please read through the parent handbook as it is a guide to our policies and procedures. Don't forget to bring a copy of current immunizations, birth certificate, and baptismal record (if applicable). Please call with questions.

We look forward to having you in our KSA ECC Family!

Blessings,

Kaitlin Dignam

Director of Kearns-Saint Ann Early Childhood Center

___FULL-TIME
___PART TIME

START DATE
____

KEARNS-SAINT ANN
Early Childhood Center
REGISTRATION FORM

Parent or Guardian's Name (please print)____

Guardian 1 email:______________________ Guardian 2 email:______________________

Address:___________________________________City:___________________Zip___________
Child's
Name:____D.O.B____________

Child's
Name:____D.O.B____________

Child's
Name:____D.O.B____________

Registration Fee $100/child $__________________

8 weeks – 2 yr
7:00 a.m. – 6:00 p.m. $900.00/month $__________________

2 yr old
7:00 a.m. - 6:00 p.m. $800.00/month $__________________
8:00 a.m. – 12:00 noon $450.00/month $__________________

3 yr old Pre-School
7:00 a.m. - 6:00 p.m. $750.00/month $__________________
8:00 a.m.-12:00 noon $475.00/month $__________________
7:00 a.m.-6:00 p.m. M,W,F $375.00/month $_________________
8:00 a.m.-12:00 noon M,W,F $245.00/month $__________________

Pre-K extended
11:30 a.m. – 6:00p.m. $450.00/month $_________________

CHECK #________
RECEIPT# ______

TOTAL $_________________

PAYMENT $_________________

BALANCE DUE $_________________

Parent or Guardian Signature:

_____________________________________Date______________

Phone # Work: ___________________ Home: ___________________ Cell: __________________

KEARNS – ST. ANN SCHOOL
CHECKING/SAVINGS ACCOUNT DEBIT AUTHORIZATION
Please complete AND attach VOIDED check

Name (s) (exactly as shown on account)

____ ________________________________

Street Address City State Zip

____ ________________________________

Home Phone CELL Phone Work Phone

____ ________________________________

Student/Grade Student/Grade

____ ________________________________

Student/Grade Student/Grade

The following account information is a _____Checking Account _____Savings Account

____

Name of Financial Institution

____

Transit Routing Number

____

Account Number

I authorize KEARNS – ST. ANN School and Extended Day Program to automatically deduct my monthly **Tuition/Extended Day Care Payments** from the above referenced account. I understand this authorization will remain in effect until I provide written notice of termination in such time and in such manner as to afford KEARNS – ST. ANN SCHOOL and Extended Day Program a reasonable opportunity to act on it (minimum of 7 business days notice prior to effective date). I understand it is my responsibility to notify KEARNS – ST. ANN SCHOOL and Extended Day Program of any change in student(s) enrollment. I understand KEARNS – ST. ANN School and Extended Day Program reserve the right to terminate this service at any time.

____ _____/_____/_____

Signature (required for validation) Date

Terms of service: KEARNS – ST. ANN **School Tuition Debits** will be made on the 20th day of each month, beginning August and ending May each school year student(s) is enrolled. KEARNS – ST. ANN **Early Childbood Center** charges will be made on the 10h day of each month. KEARNS – ST. ANN SCHOOL is not responsible for bank account charges, NSF, or other bank fees, or overdrafts caused by automatic transactions. KEARNS – ST. ANN SCHOOL and Early Childhood Center will assess a $25.00 NSF FEE on all transactions returned for non-sufficient funds.

Kearns-Saint Ann Early Childhood Center Emergency Contact Form

Mark One: □Full Time □ Part Time

Name: ________________________________ Birth Date: ___________ Enrollment Date:___________

Home Address: _______________________________ Zip: _________ Home Phone: _____________

Student Lives With: Both Parents □ Mother □ Father □ Other Student's Grade: __ Sex: ______

Father/Guardian's Name: ________________________________ Cell #: _____________________

Employer: ____________________________________ Work Phone: _____________________

Mother/Guardian's Name: ______________________________ Cell #: _____________________

Employer: _________________________________ Work Phone: _____________________

Persons designated to pick up child:

	Name	Relationship	Work/Home Phone	Cell
1.				
2.				
3.				

Persons who may be called in case of illness or emergency if parent cannot be reached:

	Name	Relationship	Work/Home Phone	Cell
1.				
2.				

Child's Physician: ___________________________________ Phone: ______________________

Describe any pertinent social information or special needs of the child:

Describe any physical or medical problems of the child, i.e. seizures, asthma, diabetes, allergies, heart disease, respiratory illness, drug reaction, speech difficulties, etc.:

Give instructions for the care of the above-mentioned problems:

In case of serious emergency or illness, when a parent cannot be reached immediately, I hereby authorize the childcare giver to obtain emergency medical care, i.e. physician, dentist, paramedics or other authorized emergency agents.

____ Date: _______________________

Signature of Parent or Guardian

MEDICAL RELEASE FORM

This is a medical release for a minor child, which may permit treatment in an emergency. While there are other methods for hospitals and other medical facilities to obtain permission to treat a minor child in the absence of parental consent, it is a good idea to have one of these permission slips on file in the office, in the teacher's backpack, in the child's doctor's office, as well as the nearest hospital to be sure there is no delay in case of an emergency.

The information must be updated annually or more often if the information contained herein changes.
Please print the following information.

I, ________________________ Parent or Legal Guardian of ___________________________,

a minor child, hereby authorize any medical or surgical treatment that may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor. I agree to hold the physician or hospital treating the above-mentioned minor harmless. I also give the hospital permission to release information to my insurance company(s) and give them permission to collect payment from said insurance company(s).

Child's Name _________________________ Grade _______ Date of Birth _________________
Medication currently taking: ____
Regular Physician: ______________________ Phone Number: _____________________________
Insurance Co: __________________________ ID Number: _______________________________

Home Address: _________________________ Home Phone: ______________________________
Father's Name: __________________________ Cell Phone: ______________________________
Employer: _____________________________ Work Phone: ______________________________
Mother's Name: ________________________ Cell Phone: ________________________________
Employer: ____________________________ Work Phone: ______________________________

Describe in full any allergies (drug, food, insect bites, etc.) or limitations on physical activity,
Drug Allergies: ______________________________
Food Allergies: ______________________________
Other Allergies: ______________________________
Physical Limitations: __________________________

Name of person other than guardian to contact in case of an emergency:
Name:_____________________________ Relationship: __________________________________
Address: ___________________________ Phone: ____

Signature of Parent/Legal Guardian ____________________________________ Date: _____

Parental Permission Form
Student Photographs/Video

During the course of the school year, Kearns-Saint Ann School publishes newsletters, a school brochure, and other materials for information and recruitment purposes. Within the context of these publications, the photographs or videos of school-sponsored activities and events, as well as photos and/or videos of students and faculty, are usually included. *The Catholic Diocese of Salt Lake City also occasionally asks for pictures and/or videos of our students.*

I/We do hereby give permission for Kearns-Saint Ann School to use photographs/videos of my child (ren) as part of school or *Diocesan brochures*, websites or other promotional materials. I understand that neither child (ren) nor I will receive any financial remuneration for this publicity.

I/We give my/our permission to use *photographs/videos* of my child (ren) during the time he/she/they are enrolled in Kearns-St. Ann School.

List names of each child (first and last)

1. ____
2. ____
3. ____
4. ____
5. ____

Photograph Yes_____ No_____

Signed: ______________________________ Date: ________________
Mother or Legal Guardian

Signed: ______________________________ Date: ________________
Father or Legal Guardian

Kearns-Saint Ann School 430 East 2100 South Salt Lake City, Utah 84115
(801) 486-0741 (FAX) 486-0742