



CAHABA VALLEY LEARNING CENTER

151 Narrows Parkway, Suite E, Birmingham, Alabama 35242

Enrollment Agreement (Waitlist Agreement)

I, _____, hereby wish to enroll my child(ren)

1). _____,

2). _____,

3). _____,

in Cahaba Valley Learning Center.

_____ (initial) I am securing my child(ren)'s placement in their classroom by paying a deposit of \$_____. I understand that this deposit will be applied to the first weeks tuition, but is NON-REFUNDABLE should I not bring my child(ren) (for any reason).

_____ (initial) I also understand that should that need arise to un-enroll my child(ren), I must give a written two (2) weeks' notice to Cahaba Valley Learning Center.

_____ (initial) I understand that by enrolling my child(ren) in Cahaba Valley Learning Center, tuition is due and payable on Monday of each week and a late fee of \$10.00 (ten dollars) will be assessed for payments received after 6:00 pm on Wednesday.

Signed this _____ day of _____, 2014.

Parent/Guardian

Social Security Number

Parent/Guardian

Social Security Number

This binding agreement will be kept in a secure location. Any unpaid tuition expenses will be collected in Shelby County Small Claims Court. Customer is responsible for all collection expenses including attorney and court fees.

205-437-8900

www.cahabavalleylearning.com



CAHABA VALLEY LEARNING CENTER

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FEE SCHEDULE (EFFECTIVE 1/1/2015)

Camera Viewing Fees \$free

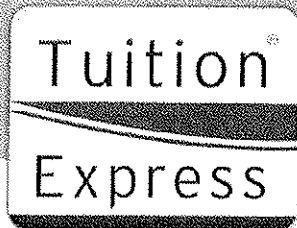
Meals \$free

Registration (per child) \$free

Age	Weekly Rate
6 weeks - less than 12 months	\$195.00
12 months - 24 months	\$190.00
2 year olds	\$185.00
3 year olds	\$180.00
4 year olds	\$170.00
Prek	\$170.00
Afterschool care	\$ 60.00

Discounts

- 1st child Normal weekly rate
- 2nd child 10% off weekly rate
- 3rd child 15% off weekly rate
- 4th child 15% off weekly rate



*Convenient and Safe
On-time Payments*



PARENT FAQs

We are excited to offer automatic payments through Tuition Express. It is no longer necessary for you to write a check for tuition and fees. Your bank or credit card account will be safely and securely debited by Tuition Express. You can be emailed a receipt for each transaction. It's easy to sign-up – just ask us.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?

Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, steal your identity. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?

Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?

If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?

Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize your bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?

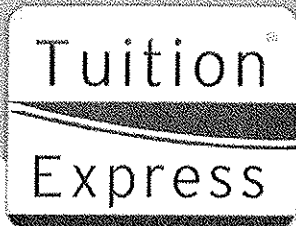
Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?

For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.



*Automated Payment Processing
Safe – Convenient – Easy*

We are excited to offer the safety, convenience and ease of Tuition Express® – an automatic payment processing system that allows on-time tuition and fee payments to be made with your credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR CREDIT CARD AUTHORIZATION

I (we) hereby authorize _____ (business name) to initiate recurring credit card charges to the below referenced credit card account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

Cardholder Name

Phone #

Cardholder Address

City

State

Zip

Account Number

Expiration Date

Cardholder Signature

Date

For Official Use Only

Date Received

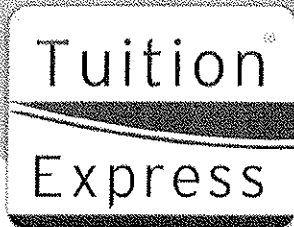
Employee Signature

A service of



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Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition ExpressSM – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AUTHORIZATION

I (we) hereby authorize _____ (business name) to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____		Phone # _____	
Address _____		City _____	State _____ Zip _____
Bank or Credit Union Name _____			
Bank or Credit Union Address _____		City _____	State _____ Zip _____
		<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Routing Transit Number (see sample below) _____		Account Number (see sample below) _____	
Signature _____		Date _____	

For Official Use Only

Date Received _____

Employee Signature _____

John Sample Mary Sample 123 Nice Street Anytown, USA		BANK OF THE WEST 555-555-5555		00226
Pay to the order of: _____		Attach Voided Check Here \$ _____		
Deposit slips not accepted		Dollars _____		
1234567890	18003308	0226		
Routing Number	Account Number	Check Number		

A service of



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Child's Preadmission Record (continued) - page two of two - form not valid without first page

Describe any special needs or instructions below:

Person(s) the child may be released to:

Name	Relationship to child	Address	Telephone number

I understand that the Department of Human Resources does not inspect activities away from the child care facility (home or center). The licensee of the child care facility assumes full responsibility for such activities.

_____/_____
Signature of parent/guardian Date

I give permission for my child to participate in:

(Circle yes or no and sign each line)

Activities away from the facility:	yes	no	Signature of parent/guardian	Date
Transportation provided by the facility:	yes	no	Signature of parent/guardian	Date
Swimming/wading activities provided by the facility:	yes	no	Signature of parent/guardian	Date

Form not valid without signature of child's parent/guardian in each space indicated above.

This section is to be completed by the facility's staff.

Child's first day of attendance: _____ Child's withdrawal date: _____

Additional information may be attached.



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About Your Child (age 6 wks – 23 months)

Please answer only the questions that apply to your child. If the answer is n/a or if you feel uncomfortable answering any item, then the line can be left blank.

1. What FOODS does your child especially like? _____
2. Especially DISLIKE? _____
3. Favorite toys, games, activities? _____
4. Is your child on formula or breast milk? _____ If Formula, what brand? _____
5. How frequently (approx.) is your child fed? _____
6. Does your child have any special FEARS? _____
Explain _____
7. When your child is upset, what helps to COMFORT him/her? _____
8. How does your child express ANGER or frustration? _____
9. How frequently (approx.) does your child NAP? _____ Approx. how long? _____
10. Is your child accustomed to having a toy or blanket for NAP? _____
11. What is your child's disposition upon waking up? happy, grouchy, clingy, slow, _____
12. Special FAMILY situations? (such as *custody specifications, problems arising from situations, etc.*) _____

13. Anticipated ADJUSTMENT problems? _____
14. Any disorders/developmental (slow, advanced) diagnosed or suspected? _____

15. Previous childcare child has attended: _____
16. Any problems at previous daycares? _____
17. What different would you like to see take place at our center _____
18. Any brothers or sisters at home? (Please list age) _____
- Other COMMENTS? _____



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Health History

1. Child's name _____ Birth Date _____
2. Last Physical Examination _____
3. Has or does your child have any known health problems? () yes () no If yes, describe: _____
4. Does your child need regular medication? () yes () no If yes, what and when is it given? _____
5. Does your child have any known allergies? () yes () no If yes, please list allergens: _____
6. Special instructions in case of an allergic reaction: _____

7. Illnesses: (if yes, please circle and list approximate date)

Does your child have any problems with any of these?

- | |
|--------------------------------------------------|
| <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Frequent Sore Throats |
| <input type="checkbox"/> Lice |
| <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Stomach Upsets |
| <input type="checkbox"/> Urinary Problem |
| <input type="checkbox"/> Worms |

Has your child had any of these diseases?

- | |
|-----------------------------------------|
| <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Impetigo |
| <input type="checkbox"/> Measles |
| <input type="checkbox"/> Mumps |
| <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Polio |
| <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Whooping Cough |

8. Other ILLNESSES? (besides above) _____
9. Has your child been HOSPITALIZED? (explain) _____
10. Has your child had INJURIES with fractures or loss of consciousness? (explain) _____
11. Last VISION Test Date _____ Last HEARING Test Date _____
12. Last DENTIST Visit Date _____
13. Any other members of your family with SERIOUS ILLNESS recently? (explain) _____
14. Any other members of your family history of: ASTHMA ____ DIABETES ____ EPILEPSY ____



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Please provide an example of a typical day in your child's life: (be sure to include eating, napping, playtime, etc.)



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About Your Child (age 24 months – pre k)

Please answer only the questions that apply to your child. If the answer is n/a or if you feel uncomfortable answering any item, then the line can be left blank.

1. What FOODS does your child especially like? _____
2. Especially DISLIKE? _____
3. Favorite toys, games, activities? _____
4. Is your child TOILET TRAINED? _____ What words does your child use for toilet? _____
5. How frequently (approx.) is your child fed? _____
6. Does your child have any special FEARS? _____
Explain _____
7. When your child is upset, what helps to COMFORT him/her? _____
8. How does your child express ANGER or frustration? _____
9. How frequently (approx.) does your child NAP? _____ Approx. how long? _____
10. Is your child accustomed to having a toy or blanket for NAP? _____
11. What is your child's disposition upon waking up? happy, grouchy, clingy, slow, _____
12. Special FAMILY situations? (such as custody specifications, problems arising from situations, etc.) _____

13. Anticipated ADJUSTMENT problems? _____
14. Any disorders/developmental (slow, advanced) diagnosed or suspected? _____

15. Previous childcare child has attended: _____
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17. What different would you like to see take place at our center _____
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4. Does your child need regular medication? () yes () no If yes, what and when is it given? _____
5. Does your child have any known allergies? () yes () no If yes, please list allergens: _____
6. Special instructions in case of an allergic reaction: _____

7. Illnesses: (if yes, please circle and list approximate date)

Does your child have any problems with any of these?

Has your child had any of these diseases?

<input type="checkbox"/> Constipation	<input type="checkbox"/> Asthma
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Impetigo
<input type="checkbox"/> Lice	<input type="checkbox"/> Measles
<input type="checkbox"/> Ringworm	<input type="checkbox"/> Mumps
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> German Measles
<input type="checkbox"/> Soiling	<input type="checkbox"/> Polio
<input type="checkbox"/> Stomach Upsets	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Urinary Problem	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Worms	<input type="checkbox"/> Whooping Cough

8. Other ILLNESSES? (besides above) _____
9. Has your child been HOSPITALIZED? (explain) _____
10. Has your child had INJURIES with fractures or loss of consciousness? (explain) _____
11. Last VISION Test Date _____ Last HEARING Test Date _____
12. Last DENTIST Visit Date _____
13. Any other members of your family with SERIOUS ILLNESS recently? (explain) _____
14. Any other members of your family history of: ASTHMA _____ DIABETES _____ EPILEPSY _____



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Activity Authorization Form

I hereby grant permission for my child/children named below to use all of the play equipment and participate in all of the activities on the premises of Cahaba Valley Learning Center

Name of child: _____ Age: _____

I understand that ride on toys, chairs, sprinklers, sandboxes, slides, and other toys are used on a regular basis (weather permitting).

Comments _____

Please do not allow my child to play on the following equipment in your playground or participate in the following activities:

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date
Provider/ signature	Date



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Substances	Child's Information					(Check if allergic)	
	MAY Be exposed	May NOT be exposed	IS allergic	Is NOT allergic	Not Sure	Parent(s)	Other Family Member
Foods:							
Peanuts							
Other nuts & seeds							
Citrus fruits							
Other fruits							
Cow's milk							
Yogurt							
Other dairy							
Corn							
Oats							
Wheat							
Other grains							
Yeast							
Egg yolks							
Egg whites							
Soy foods							
Fish							
Shell fish							
Environmental:							
Dust							
Mold spores							
Cats							
Dogs							
Other animals							
Pollen							
Bee stings							
Medical:							
Penicillin							
Latex							
Other (please list):							

Name of Center: Cahaba Valley Learning Center, Inc.



Infant/Toddler Safe Sleep Policy Sample (Revised)

Date Adopted: August 1, 2009

Safe Sleep Practices

1. All child care staff working in this room, or child care staff who may potentially work in this room, will receive training on our Infant Safe Sleep Policy.
2. Infants will always be placed on their backs to sleep, unless there is a signed sleep position medical waiver on file. In that case, a waiver notice will be posted at the infant's crib and the waiver filed in the infant's file.
3. The American Academy of Pediatrics recommends that babies are placed on their back to sleep, but when babies can easily turn over from the back to the stomach, they can be allowed to adopt whatever position they prefer for sleep.
4. We will follow this recommendation by the American Academy of Pediatrics. However, child care staff can further discuss with parents how to address circumstances when the baby turns onto their stomach or side.
5. **Visually checking sleeping infants.** Sleeping infants will be checked daily, every 15-20 minutes, by assigned staff. The sleep information will be recorded on a Sleep Chart. The Sleep Chart will be kept on file for one month after the reporting month. We will be especially alert to monitoring a sleeping infant during the first weeks the infant is in child care.
We will check to see if the infant's skin color is normal, watch the rise and fall of the chest to observe breathing and look to see if the infant is sleeping soundly. We will check the infant for signs of overheating including flushed skin color, body temperature by touch and restlessness.
6. Steps will be taken to keep babies from getting too warm or overheating by regulating the room temperature, avoiding excess bedding and not over-dressing or over-wrapping the baby.

Safe Sleep Environment

7. Room temperature will be kept between 68-75°F and a **thermometer kept in the infant room.**
8. Infants' heads will not be covered with blankets or bedding. Infants' cribs will not be covered with blankets or bedding. **We may use a sleep sack instead of a blanket.**
9. No loose bedding, blankets, pillows, bumper pads, etc. will be used in cribs.
10. Toys and stuffed animals will be removed from the crib when the infant is sleeping. **Pacifiers will be allowed in infants' cribs while they sleep.**
11. A safety-approved crib with a firm mattress and tight fitting sheet will be used.
12. Only one infant will be in a crib at a time, unless we are evacuating infants in an emergency.
13. No smoking is permitted in the infant room or on the premises.
14. All parents/guardians of infants cared for in the infant room will receive a written copy of our Infant/Toddler Safe Sleep Policy before enrollment.
15. **To promote healthy development, awake infants will be given supervised "tummy time" for exercise and for play.**

I, the undersigned parent or guardian of _____ (child's full name), do hereby state that I have read and received a copy of the facility's Infant/Toddler Safe Sleep Policy and that the facility's director/ owner/operator (or other designated staff member) has discussed the facility's Infant/Toddler Safe Sleep Policy with me.

Date of Child's Enrollment: _____

Signature of Parent or Guardian: _____

Date: _____

Signature of Child Care Provider: _____

Date: _____

Distribution: one signed copy to parent(s)/guardian(s); signed copy in child's facility record.

Parent Release Form for Media Recording

I, the undersigned, do hereby grant/deny permission to Cahaba Valley Learning Center to use the image of my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or other use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Cahaba Valley Learning Center Web site. I agree to participate in the project without financial remuneration, and I understand that this releases the school/photographer from any future claims, as well as from any liability, arising from the use of the said photograph.

- ☐ Deny permission to use my child's image at all.
- ☐ Grant permission to use my child's image in the following ways (mark all that apply):
 - ☐ **Limited usage:** I wish my child's image to be used within the Cahaba Valley Learning Center setting only (not in the larger community).
 - ☐ **Limited usage:** I wish my child's image to be used for educational materials only (not marketing). This could be either within Cahaba Valley Learning Center or in the larger community. One example of this could be videos in parent education classes.
 - ☐ **Limited usage:** I wish my child's image to be used on printed materials only (no digital or video usage).
 - ☐ **Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by Cahaba Valley Learning Center for a variety of purposes and that these images may be used without further notification. I do understand that the child's surname will not be used in conjunction with any video or digital images.

Parent/guardian signature _____ Date _____

Please make a copy of this form for your own records and post or fax the original to:

Director
Cahaba Valley Learning Center
151 Narrows Parkway
Birmingham, AL 35242
Fax: 437-8907

If you have questions, please contact Amanda Hall @ 205-437-8900



CAHABA VALLEY LEARNING CENTER
151 Narrows Parkway, Suite E, Birmingham, Alabama 35242

Acknowledgement of Receipt

Form Title:	(Please check one)	
	Received	Did NOT Receive
About Your Child Form		
Parent Handbook/Operating Policy		
Activity Authorization		
Food and Allergy Form		
Other (please list):		
Safe Sleep Policy		
Fee Schedule		

By signing below, I acknowledge receipt of the above listed forms, and agree to abide by the terms and policies as outlined in them.

(Parent or guardian)

(Date)

(Parent or guardian)

(Date)

(Child Care provider)

(Date)

I. Authorization for administering medication

DHR-CDC-1949

AUTHORIZATION FOR ADMINISTERING MEDICATION/MEDICAL PROCEDURES

Dear Parent/guardian,

Your written permission is required to administer medication or medical procedures to your child. Any prescription drug or over-the-counter drug sent to the child care facility (home or center) must be in its original container and must be clearly labeled with your child's name, the name of the drug, and directions for administering the drug. A new authorization form is needed each week. If it is absolutely necessary for your child to be given medication while at the child care facility, please complete the following information.

Child's Name _____

Prescription Number _____

Name of Medication _____

Amount of medication to be given at each dosage _____

Instructions (how to give or apply, such as give by mouth, apply to skin, inhale, drops in eyes, etc.) _____

Time and date of last dosage given at home _____

Time(s) of dosage(s) to be given at the child care facility _____

Please give my child the above-named medication at the time(s) and in the amount(s) indicated.

Signature of parent/guardian

Date

To be completed by licensee/staff/caregiver

Date medication given	Time medication given	Signature of person giving medication

Attention Parents!

Sign up for text alerts to be notified of school closings, emergencies, and other special events!

To sign up, follow these easy steps:

- Text @cvlc to 404-620-3938
- You will receive a response confirming your subscription

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