Themba Creative Learning Center, LLC. ACKNOWLEDGMENT OF ENROLLMENT DEPOSIT

The deposit guarantees you space for your child (or children) in the appropriate classroom(s) when space becomes available. Enrollment space is reserved and secured with a deposit for up-to 2-months to the desired start date of enrollment.

Your deposit will be held for one day (24 hours) in order to allow parents to read through and understand the Enrollment Agreement. A signed Agreement returned within 24 hours ensures the child's place and commits the parent(s) to all policies and procedures. If the agreement is returned unsigned within 24 hours, it is assumed that the child is not enrolled. No space will be held and the deposit check will be returned.

If an Agreement is not returned within 24 hours --signed or unsigned, the space is forfeited and the deposit is forfeited.

If a space is available immediately in the appropriate classroom, the parent(s) may fulfill all of the requirements as soon as possible, the same day if necessary, and the child may be enrolled in the class. A space is not held without a deposit. Your deposit is credited to your first week of tuition.

The deposit required to reserve a space i Classroom.	s \$The child will be enrolled in the
A deposit in the amount of \$ reserve a space for	has been received from
(Child's Name)	
This deposit will be held for 24 hours	me) from the time noted above. A signed Agreement must be returne space. Failure to return an unsigned Agreement within 24 hours
I understand and agree to the above.	
Parent's Signature	
Parent's Signature	Date/Time
	Date/Time
Center Director's/Assistant Director's	Signature Date/Time

EMERGENCY FORM

Check the meal(s) that your child receives: BF AM LUN PM_ SUP

Allergies:

INSTRUCTIONS TO PARENTS:

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

(1) Complete all items on this side of the form. Sign and date where indicated.(2) If your child has a medical condition, which might require emergency medical care. If necessary, have your child's health practitioner review that information.

hild's Name		Last		Birth Date First	
nrollment Date		Hours & Days of	Expected Attendance	e	
nild's Home Address					
Street/Apt.	‡	City		State	Zip Code
Parent/Guardian Name(s)	Relationship	Phone Number(s)			
		Place of Employmer	ıt:	C:	H:
		W:			
		Place of Employmer	it:	C:	H:
		W:			
d's Email_		Mom's Er	noil		
u S Ellidii		WOTTS ET	ııdıı		
me of Person Authorized to Pick Up Ch	nild (daily)				
	Las	t	First		Relationship to Chi
dressStreet/Apt.#		City	State	Zip Code	e
NUAL UPDATES	(Initials/Date)	(Initial	s/Date) - — — — — —	(Initials/Date)	
nen parents/guardians cannot be reach	ed, list at least one pers	son who may be contac	sted to pick up the ch	ild in an emergency:	
Name			_Telephone (H)	(W)	
	Las	t	First		
AddressStreet/Apt.#		City		State	Zip Code
Name		·	Telephone (H)		
	Las	t	First		,
Address					
Street/Apt.#		City		State	Zip Code
ild's Physician or Source of Health Car	۵		7	Геlephone	
•	<u> </u>			. сторионо	
dress Street/Apt.#		City		State	Zip Code
EMERGENCIES requiring immediate m	nedical attention, your o	-	NEAREST HOSPIT		·
thorizes the responsible person at the c				AL LINENGENOT RO	om. Tour signature
anature of Parent/Guardian			Da	4-	

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s), which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name:	Date of Birth:
Allergies/Reactions:	
EMERGENCY MEDICAL INSTRUCTIONS:	
(2) If signs/symptoms appear, do this:	
(3) To prevent incidents:	
OTHER SPECIAL MEDICAL PROCEDURES THAT	MAY BE NEEDED:
COMMENTS:	
Note to Health Practitioner:	
If you have reviewed the above information,	, please complete the following:
Name of Health Practitioner	Date
Signature of Health Practitioner	() Telephone Number