Enrollment Form 2026-27: Seeds of Joy Christian Nursery School.

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state childcare licensing regulations.

Child's Information:

Child's first name	Child's middle name	Child's last name	Child's nickname

Age	Sex	Child's primary language	Parent/guardian/sponsor primary language

Child's home address	City	State	Zip

Does your child attend school? □ Yes □ No	School name SEEDS OF JOY NS	School address 4 S. RIDGE AVE, AMBLER, PA 19002	School phone 267-644-5688

Enrolling in the following for 2025-2026: Circle choice: AM Programs:	PM Programs: Circle your choice	Early Arrival: $15 per day
2 yr old T-Th. 2 yr old M, W, F 3 yr old M-TH. 3 yr old T, W, Th. 4 yr old M-Th. 4 yr old M-F	Lunch munchers: 2 days 3 days 4 days. 5 days Learning Extenders: 3 days 4 days 5 days	Yes No Days: __________

Family Information

List family members & pets your child lives with – include first names, relation, and ages of siblings

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone

Home address if different from above	City	State	Zip

Home email	Work email	Work phone

Employer	Employer address	City	State	Zip	Work hours

Other parent/guardian/sponsor	Relationship to child	Home phone	Cell phone

Home address if different from above	City	State	Zip

Home email	Work email	Work phone

Employer	Employer address	City	State	Zip	Work hours

Child Emergency Contact and Release Information

Complete in entirety: The Emergency Contact Parental Consent Form 55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

Initial:

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick-up persons with whom staff is not familiar provide a photo ID at the time of pick-up.] _______

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed below. If you want a person who is not identified above to pick up. your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization. ______

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

Name		
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOMETELEPHONE NUMBER
E-MAILADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOMETELEPHONE NUMBER
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S) (NOT PARENTS)	NAME	TELEPHONE NUMBER WHEN IN CHILDCARE
	ADDRESS	
PERSON(S) TO VI.HOM CHILD MAY BE RELEASED	NAME ADDRESS	TELEPHONE NUMBER (WHEN in CHILD CARE)
NAME OF CHLD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)	
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION. SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN.OF MINOR FIRST AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY		

SIGNATURE OF PARENT OR GUARDIAN — DATE

Periodic Review: 6 months from above

SIGNATURE OF PARENT OR GUARDIAN — DATE

Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color

Distinguishing marks, if any:

Child's Medical & Developmental History

- Does your child have any special medical conditions? No Yes Explain
- Does your child have any chronic illnesses? No Yes Explain
- Please list a brief history of your child's serious injuries and hospitalizations.
- Does your child have diabetes? No Yes *If yes, please attach care instructions from your physician.*
- Does your child have asthma? No Yes *If yes, please attach care instructions from your physician.*
- Will medication be administered regularly? No Yes *If yes, please attach care instructions from your physician.*
- Does your child have any special dietary needs? No Yes Explain
- Is your child able to fully participate in all activities? Yes No Explain
- Does your child have any physical restrictions? No Yes Explain
- Can your child communicate his/her need Yes No Yes Explain
- Does your child need assistance at mealtime? No Yes Explain
- Is your child toilet trained? No Yes
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.?
  No Yes Explain
- Does your child require one-to-one care/supervision on a regular basis for a significant period of time?
  No Yes Explain
- Does your child require any accommodations or modifications to enjoy and participate in a group care setting fully and equally?
  No Yes Explain

Medical Information (continued)

Child's name	Birth date

Illness History *(please check all that apply)*

- Vision problems
- Hearing problems
- Constipation
- Diarrhea
- Asthma/breathing problems
- Nosebleeds
- Skin rashes
- Sore throats
- Ear infections
- Urinary tract infections
- Seizures
- Mouth sores
- Fainting
- Persistent cough
- Other

Please attach care instructions from your physician for any of these illnesses.

Disease History *(please check all that apply and add the date)*

- Chicken Pox ____________
- Measles Rubeola ____________
- ____________
- Mumps ____________
- Scarlet Fever ____________
- Bronchiolitis ____________
- Pneumonia ____________
- Tetanus ____________
- Diphtheria
- Botulism
- Hemophilus Influenza
- Rabies
- Bacterial Meningitis

Allergies (please list)

Medication Allergies:

Medication	Reaction
____________	____________
____________	____________
____________	____________

Food Allergies:

Food	Reaction
____________	____________
____________	____________
____________	____________

Insect Bite Allergies:

Insect Type	Reaction
____________	____________
____________	____________

Respiratory Allergies:

Type	Reaction
____________	____________
____________	____________

Other Allergies:

Type	Reaction	Type	Reaction
____________	____________	____________	____________
____________	____________	____________	____________

Are any of these allergies life-threatening? _Yes _No Please *attach care instructions from your physician for any life-threatening allergies.*

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

- Vision____________
- Developmental____________
- Tuberculosis (PPD)____________
- Hearing____________
- Aptitude____________
- Sickle Cell Anemia____________
- Speech ____________
- Educational ____________
- Other____________ ____________

Medical Information (continued)

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone

Physician's practice address	City	State	Zip

Preferred hospital/clinic for emergency care	City	State

Dentist's name	Dentist's practice name	Phone

Dentist's practice address	City	State	Zip

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received. Immunizations in bold are required by the state of Pennsylvania.

Anthrax	Influenza	**Pneumococcal disease**	Smallpox
Diphtheria	Lyme Disease	**Polio**	**Tetanus**
Haemophilus Influenzae type b (Hib)	**Measles**	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	**Mumps**	**Rubella**	**Varicella (Chickenpox)**
Human Papillomavirus (HPV)	**Pertussis (Whooping Cough)**	Shingles (Herpes Zoster)	Yellow Fever

Additional Medical Policies

Initial

1. Prior to enrollment, I must provide Seeds of Joy with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state childcare regulations. ________
2. I agree to provide information to Seeds of Joy about my child's conditions, illnesses, allergies, or other needs. ________
3. If my child becomes ill during his/her time at Seeds of Joy, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*. ________
4. I agree to the mandatory closure policy outlined in the SOJ Family Handbook ________

Emergency Medical Authorization & Consent

Initial

In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician. ________

In case of a medical emergency, I agree that my child may receive first aid and/or CPR. ________

In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary, by paramedics or other emergency personnel. ________

In case of a medical emergency, I will be responsible for the emergency medical expenses. ________

In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. ________

Initial

I give my permission to Seeds of Joy to apply ☐ sunscreen and ☐ insect repellant to my child. *Please check which products you will permit.* I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name. ________

I ☐ have ☐ do not have special instructions for the application process. ____________________

Rate Agreement and Contract

Child's name | Birth date

Hours of Operation

Operating hours are **8:30am to 2:45pm,** except closings for various holidays, and inclement weather as described in the Seeds of Joy Handbook. **Early drop off is available at 8:30 am for an extra fee** and subject to availability. **Carline will run from 9:00 am-9:10 am with drop off in the lobby of the church. AM Classroom hours are 9:15-11:45, 11:45-12:45, 12:45-2:45 pm.** Please consult the current calendar for holidays. There is no reduction in tuition because of closures.
The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on our Facebook page and via ProCare messages. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for nursery school are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Payments will be made monthly, one month in advance on the 15th of the month prior. I agree to pay ________for my monthly tuition.

Fee Policy

Initial Below:

________ **The first monthly tuition is due July 15th (for September) Tuition is then payable by the 15th of the month, one month in advance. (e.g. on September 15th, October tuition is due.) There will be 9 equal payments: July 15th, Sept 15 - April 15th.**

_________ I agree to pay the full tuition in advance of services rendered.

_________ I agree to pay the full tuition fee even if my child is absent for one or more days.

_________ A late fee of $25 will be due if tuition payment is not received by the 25th of the month.

_________ A non-refundable registration fee of $75 is due yearly. This fee will be used for special programs or field trips through the permission slip will be required for your child's participation.

__________Accounts two weeks in arrears may result in immediate termination of service.

_________ All returned checks or ACH transactions (automatic debits) will be charged a fee of $36. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status.

_________ A two-week written notice is required for any child being withdrawn from any of the programs including part-time, full-time programs. Failure to provide notice in writing will result in forfeiture of deposit.

_________ A receipt for income tax purposes ☐ should ☐ should not be provided.

Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of Seeds of Joy (i.e., childcare), outside of the programs and services offered by Seeds of Joy, is an individual endeavor and private matter not connected to or sanctioned by Seeds of Joy. Seeds of Joy shall remain harmless from any such arrangement.
Initial: ___________

Other Agreements *(continued)*

Walking Excursions

Initial

I give my permission for my child to participate in supervised walking excursions near and around Seeds of Joy Nursery School. ---------

Handbook Acknowledgement

Initial

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Seeds of Joy Family Handbook and agree to abide by them. ________

I understand that it is my responsibility to go directly to the Director with any questions I may have regarding the policies and procedures and information contained in the Seeds of Joy Enrollment Agreement. ________

Information contained in the Seeds of Joy Family Handbook may be subject to change. ________

Photo Release

I give my permission that any photo containing my child participating in Seeds of Joy program activities may be used on any of the First Presbyterian Church of Ambler's public social media sites, such as the church's Facebook page, Seeds of Joy's Facebook page or group and on any social media site that Seeds of Joy chooses to post pictures or in local news social media publications. ______

Contract Approval

I certify that I have read, understand, and accept all the terms and conditions described in this *Enrollment Agreement*.

Primary Parent/Guardian/Sponsor Signature	Date	Seeds of Joy Staff Signature	Date