All Star Daycare
2 Hartford Ave. Suite 200
Des Moines IA 50315
282-6516

Child's full name _____Date of Birth _____
Child's address _____Phone_____
Street City State Zip Code

Parents or Guardians

Name _____ Name _____
Home address _____ Home address _____
_____ _____
Home phone _____ Home phone _____
Work phone _____ Work phone _____
Employer _____ Employer _____
Social security number _____ Social security number _____
E-mail address _____ E-mail address _____

How did you find out about us?_____

List every person with authority to pick up your child
_____ _____
_____ _____

Anyone **NOT** permitted to pick up child (with copy of court order if applicable)
_____

Physical Information

Allergies _____
Medications _____
_____

Does your child have any unusual eating habits? Likes? Dislikes? (explain) _____
_____

Does your child usually nap? _____ Time _____ How long _____

Does your child have any special problems or fears? _____
_____
Does your child have any special interests or favorite activities? _____
_____
Does your child have any behavior problems? (explain) _____
_____

Is your child toilet trained? _____
What forms of discipline do you use with your child? _____
Parent/Guardian signature _____Date _____

Emergency Medical Authorization

I, _____ parent / guardian of _____
Date of Birth _____, do hereby give permission and / or consent to
All Star Daycare to secure and authorize such emergency medical care and / or dental treatment as the above named child might require while under the supervision of said daycare provider. I further authorize All Star Daycare to administer emergency care / treatment as required until professional medical treatment is secured as authorized under this consent.

Note: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it would be necessary to have the following information. Consent for medical care does not include a responsibility of All Star Daycare for payment of any / all medical expenses.

Physician Name _____ Phone _____

Address _____

Preferred Hospital _____

Health Insurance Plan _____ID number_____

Dentist Name _____ Phone_____

Address _____

Child's Allergies _____

If parent / guardian are unavailable other relatives or persons to contact in an emergency:

Name / Relationship Address Phone

_____

Parent / Guardian
Signature_____
Date _____

Parent / Provider Child Care Contract

The following agreement is made between Parents / Guardian and Provider of daycare for _____ Date of Birth _____
For child care services

Effective Date _____ FT _____ PT _____ Days M T W Th F
Hours of care_____ Fee is based on an 8 hour work day
Standard fee $_____ per week day
Overtime rates: **$5.00 per child / 10 minutes** Overtime fees are based on the hours of care stated above. Daycare hours are 6:30 to 5:30 (Evening hours available)

Standard fee payment is due weekly (Monday mornings) beginning on _____

Vacation: _____ days of non-attendance per year are allowed free of charge. All other times, including illness will be charged the full rate. Other provisions for childcare must be made for the following days.

New Year's Day	Memorial Day	Fourth of July
Labor Day	Thanksgiving (2 days)	Christmas (2 days)

Deposit $ _____ Registration fee $_____Date received_____

Late Payment Fee: $15.00 per day will be charged for payments due and not paid on the scheduled payment date.

Returned Check Fee: Returned checks are subject to a $30.00 service charge. Future payments must be made in cash.

If required a fee of $10.00 plus the cost of the product will be charged for the administration of Head lice Treatment.

Termination of Contract:
A two week **paid** notice is required upon termination of contract by parent / guardian.

I have read and agree to the terms and policies as stated in this contract and the All Star Daycare Policy Manual.

Parent/Guardian_____Date_____

Director Signature_____Date_____