General Policies and Tuition Agreement

Complete one per family.

Enrollment Date / /

PAYER

Primary Payer Information:
Last Name | First | MI

Daytime phone: ( ) Home / Cell / Work

Street Address | Apt # | City | State | Zip

Provide each child's daily schedule including public school schedule and transportation needs, if any.
Children may remain in care for a maximum of ten hours each day (WAC 170-295-2020). If needed, this time may be extended based upon the parent's typical work schedule and travel to and from the center. Additional fees apply.

SCHEDULE

Child:	**Child:**	**Child:**
Drop-off Time:	Drop-off Time:	Drop-off Time:
School Attending: Start Time: Transportation Needed? ☐ Yes ☐ No	School Attending: Start Time: Transportation Needed? ☐ Yes ☐ No	School Attending: Start Time: Transportation Needed? ☐ Yes ☐ No
End Time: Transportation Needed? ☐ Yes ☐ No	End Time: Transportation Needed? ☐ Yes ☐ No	End Time: Transportation Needed? ☐ Yes ☐ No
Pick-up Time:	Pick-up Time:	Pick-up Time:

Tuition payments are based off of the schedule provided above. Additional fees will apply to children in attendance outside of scheduled OR operating hours. Two weeks' PAID written notice is required prior to withdrawal from care.

TUITION AGREEMENT

PAYMENT OPTION 1 ☐
PRIVATE PAY

I agree to pay my child's tuition using Tuition Express electronics funds transfer.
I authorize payments to be withdrawn:

- ☐ monthly, on the first business day of each month.
- ☐ bi-weekly, on the Friday prior to care being provided

Combined tuition for all children:
based on payment cycle selected above $

Sibling discount:
10% off oldest child's tuition — $

Base tuition amount: $

I understand that this is the base tuition amount and that other childcare related charges and fees may be applied (ie: late pick up fees, sunscreen fees, annual registration fees, field trip and/or transportation fees, etc…).

Signature of Payer and date:

PAYMENT OPTION 2 ☐
STATE PAY

I have been approved for WCCC. Authorization #2002 __ __ __ __ __ __

Start Date: / / End Date: / /

Copayment amount: $

Is this copay reduced for the first two months? **YES** **NO**

For copays less than $50:
☐ I agree to pay my regular copayment and/or other childcare related fees that are due and payable (ie: late pick up fees, sunscreen fees, charges for insufficient funds, etc.) in **CASH** by no later than the 5th of each month.

For copays greater than $50:
☐ I agree to pay my regular copayment and/or other childcare related fees that are due and payable (ie: late pick up fees, sunscreen fees, charges for insufficient funds, etc.) via Tuition Express on the first business day of each month.

Signature of Payer and date:

AUTHORIZATION

☐ Yes ☐ No I have been given a copy of the center's Parent Handbook along with all of the items listed below. Please note, these items are also available to view at any time online at: www.playcarecenter.com.

General Enrollment Policies and Procedures
Emergency Disaster Response Plan
Tuition and Payment Policies
Pesticide Policies
Health Care Plan
Animal Policy

☐ Yes ☐ No I give my consent for my child to be photographed for center projects and displays.

☐ Yes ☐ No I give my consent for my child to have his/her finger nails trimmed as necessary to prevent injury to themselves and other children.

☐ Yes ☐ No I give permission for my child to be transported off-site in the event that the center facility must be evacuated.

☐ Yes ☐ No I give permission for my child to participate in off-site activities during operating hours using: ☐ center vehicle ☐ walking

☐ Yes ☐ No Permission to provide medical treatment to child if necessary

☐ Yes ☐ No Permission to transport child to nearest medical facility if unable to reach parent/guardian

I authorize center personnel to consent in any emergency situation to any xray examination, laboratory test, anesthetic, medical or surgical procedure or hospital care required while in their custody, and for which I am unable to be reached to provide care. Such care must be recommended by and performed under the supervision of a physician licensed to practice medicine in the United States. I understand that if transportation by ambulance is necessary, I must assume the financial responsibility.

Signature of Payer and date: