BRICK MILL EARLY CHILDHOOD CENTER

2023-2024 School Year Before and After Care
At Brick Mill Early Childhood Center
Provided by Brilliant Little Minds

Program Costs:

Before & After Care	$150/week
Before Care	$120/week
After Care	$110/week
Appoquinimink Employee	25% off tuition (must provide current ID badge)
Sibling Discount	5% off of one child with lowest tuition
Yearly Registration Fee	$100

To Register:

1. Please go to our website: www.brilliantlittleminds.com
2. Click on Forms then find the school to enroll
3. Fill out forms including auto pay form and deposit slip
4. Deposit to guarantee and hold the spot will include: First week of tuition, last week of tuition and registration fee. *This fee is not refundable for any reason!*
5. Email the forms to the main location at: blm.middletown@gmail.com
6. Please allow 5 business days for us to process your paperwork, then you will receive an email confirmation of enrollment and a receipt for payment
7. All accounts must use the auto pay form, we can not accept payments at the before/after care locations.

Important info:

- Once deposit is made it is not refundable
- Before and After Care is for the Pre-K and Kindergarten students only!
- To withdrawal from this program you must give a 30 day notice in an email to the main location
- Tuition is due every week:
  - Even if school is closed for holidays or breaks
  - Even if your child doesn't attend for sickness or vacation
  - You are paying to hold the spot for your child, due to limited space

Brilliant Little Minds Main Office info, if you have any questions:

Contact: Melissa Perez or Jenifer Clark
Phone: 302-376-9889
Email: blm.middletown@gmail.com
Website: www.brilliantlittleminds.com
Address: 102 Sandhill Dr. Middletown, DE 19709
Hours of operation: 6:30 am to 5:30 pm

BRICK MILL EARLY CHILDHOOD CENTER
Before/After Care Hours

Before Care: 6:30-9:10 am

Pre-K After Care: 3:10- 6:00 pm.

Kindergarten After Care: 3:30 – 6:00 pm

Brilliant Little Minds
LEARNING ACADEMY

New Enrollment Deposit Form

Brick Mill Early Childhood Center

Before/After Care Program

Name of child: _____ Date received: _____

Date of Birth: _____ Grade: _____

Name of Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____

Choose Care Needed: _____ Before & After Care _____ Before Care Only _____After Care Only

Start Date: _____

Deposit: (Fill out the blanks from the Program Cost Sheet)

$_____ - First Week (one week of tuition)

$_____ - Security Deposit (this is used for the last week of school = equal to one week tuition)

$ 100 - Registration Fee

$_____ : TOTAL Deposit due (Add up from above)

I understand that the deposit is not refundable for any reason. Once deposit is made in the amount of one week's tuition, security deposit and registration fee. I understand that if my child(ren) doesn't start within 2 weeks of the agreed upon date, I will either begin full payments to hold the space or forfeit the spot.

The payment will be taken from the auto pay form provided in the enrollment packet. Payments can not be accepted at the locations.

_____ _____

Signature of Parent or Guardian Date

CHILD INFORMATION CARD
State of Delaware
Department of Education

Child's Information			
Child's name:	Date of birth:	Date of enrollment:	Date of discharge:
Child's address:		Hours and days child is scheduled to attend:	

Parent/Guardian Information (1) Emergency Contact/Authorized to Pick-up Child		**Parent/Guardian Information (2)** Emergency Contact/Authorized to Pick-up Child	
Name:		Name:	
Address, if different from child's:		Address, if different from child's:	
Home phone:	Cell phone:	Home phone:	Cell phone:
Work phone:	Hours of employment:	Work phone:	Hours of employment:
Employer name and address:		Employer name and address:	

Additional Emergency Contacts and People Authorized to Pick-up Child		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:

☐ **Emergency Medical Care**

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ **Transportation**

I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

_____ _____

Signature of parent/guardian Date

Medical Information	
Name of child's physician:	Office phone:
Special medical information, medications, allergies, diet:	Health insurance identification information:

The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.

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Financial Responsibility Form – Before and After Care (revised 3/27/23)

I agree to pay a weekly tuition rate of $_____. This rate is subject to change as tuition may increase. BLM will always notify you in writing 30 days in advance if rates increase.

I agree to pay a security deposit of $_____ upon enrolling for services. It is NOT your child's first week of tuition.
_____ This deposit will be applied to your child's last week of tuition upon official withdrawal notice.

_____ I agree to pay a non-refundable yearly registration fee of $100.00.

LATE PICK UP FEE: There is a $15.00 late fee for the first 5 minutes past 6:00 pm. After 6:05pm, you will be charged an additional $5.00 per minute until pickup. Late pickup fee MUST be paid the next school day or your child's care will be
_____ suspended until paid.

_____ NSF FEE: There will be a $35.00 charge for a returned check or a non-sufficient funds check.

All Payments are due on Fridays FOR THE FOLLOWING WEEK. Any payment received after 6:00 pm on Friday evening will be considered late. There will be a $25.00 late fee that will be due the following Monday. If the late fee is not received by Monday, you will be charge an additional $5.00 a day until the balance is paid in full. All accounts must be set up on auto pay. We can not accept payments at the before/after care locations. IF you need to make a payment you can call the main office to pay by phone or stop by to make payment. If you are not setup on auto pay then you must pay 4
_____ weeks advanced tuition.

Payments are not based on attendance. All charges are based on slots occupied regardless of attendance. Tuition is still
_____ due while the schools are on break or if they are closed.

I agree that if my account balance remains unpaid for 30 days, I will be assessed a finance charge of 1.5% per month on the amount outstanding. If any payment or other charge are not made when due, BLM reserves the right to take legal action to correct all charges that are due, and may also recover legal fees, court costs and any other related expense that
_____ are incurred by Brilliant Little Minds Learning Academy.

If my child has an IEP or 504 plan then this information must be given to the office when you receive it. We need to look
_____ over the paperwork to make sure we can accommodate the requirements.

_____ There is a 5% multiple children discount applied to the lowest tuition rate.

HOLIDAYS: Should a holiday fall on a regular care day, I agree to pay my regular tuition rate. Holiday closings are listed
_____ on our Holiday Calendar Sheet.

In the event that I withdraw my child from BLM, I agree to provide 30 days advance written notice to management. I understand that my last week of tuition will be paid by my security deposit. In the event my security deposit does not cover the balance due, I agree to pay any outstanding balance to bring my account to zero at the time notice to withdraw
_____ is given.

Brilliant Little Minds reserves the right to immediately dis-enroll a child due to the following circumstances: (1) inappropriate conduct (as determined by BLM) by the child or the parent; (2) when tuition falls behind; (3) if the parent does not provide, upon request, a current written pediatrician's certification that a child is healthy and able to participate in BLM's programs without exposing other children to health risks (a.k.a updated/current Child Health Appraisal Form). (4) if parent doesn't provide 504 plan or IEP, (5) physical behavior/running away from staff and students or any behavior that may seem unsafe or if we are unable to protect.

_____ Start Date: _____ School and Grade: _____ Choose one: Before / After / Both

Parent/Guardian (1) Signature: _____ SS# _____

Parent/Guardian (2) Signature: _____ SS# _____

Brilliant Little Minds

LEARNING ACADEMY

ENROLLMENT INTERVIEW – revised 3/27/23

Help Us Get to Know You

Tell us about your family and help us understand what's important to you as a parent. Give us some insight into your child and let us in on the special relationship you have with him/her. The more we know about your wants and needs, the better we can make your *Brilliant Little Minds* experience.

Child Information:

Child's Name: _____

Child's Date of Birth: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Please list any siblings of the child:

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

Parent Interview:

1. Tell us why your child is special.

2. What kinds of things do you and your child like to do together?

3. Does your child enjoy playing with other children?

4. Does your child enjoy playing by themselves?

5. Does your child seek a lot of adult attention while playing?

6. Is Brilliant Little Minds your child's first childcare experience?

7. If not, how was their past childcare experiences like?

8. How does your child respond to having to leave you?

9. How does your child respond to strangers?

10. What can we do at Brilliant Little Minds to make you and your child's transition a smooth one?

11. How many hours does your child spend watching television per day?

12. What are your child's favorite programs?

13. What are your child's favorite toys and/or activities?

14. Has your child had any serious illness or injuries?

15. Does your child have any medical allergies?

    a. If yes, please describe.....

16. What foods does your child like?

17. What foods does your child dislike?

18. If your child potty trained?

19. Can your child dress themselves?

20. Do you have any pets?

21. If yes, please describe.....

22. Why did you choose Brilliant Little Minds for your child?

23. What are your child's best and worst times of the day?

24. What are your goals for your child at Brilliant Little Minds Learning Academy?

25. Use five words to describe your child (eg....loud, quiet, serious, affectionate, etc)

26. Have you filled out before "Ages and Stages" ? If so when and what was the results?

27. Have you witnessed behavior problems at home or at another school? If so what have you seen?

    a. Have they been evaluated by a behavior specialist? If so what are they working on? (Please provide documentation)

28. Does your child have an IEP or 504 plan?

    a. What accommodations did the school have to make?

29. Current classroom what is the size with number of children and staff?

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School Calendar
2022-2023 School Year

September	Teacher Inservice	September 1st & 2nd	Closed
	Labor Day	September 5th	Closed
	First Day of School	September 6th	First day of 2022-23 School Year
October	Columbus Day	October 10th	Closed
	Picture Day	October 21st	
November	Veterans Day	November 11th	Closed
	Thanksgiving	November 24th - 25th	Closed
December	Christmas	December 23rd,26th & 27th	Closed

-2023-

January	New Year's	January 2nd	Closed
	Martin Luther King Jr	January 16th	Closed
February	President's Day	February 20th	Closed
March	Teacher Inservice	March 24th	Closed
April	Good Friday	April 7th & 10th	Closed
	Picture Day	April 21st	
May	Memorial Day	May 29th	Closed
June	PreK Graduation	June 16th	
	Juneteenth	June 19th	Closed
July	Independence Day	July 4th & 5th	Closed
August	Teacher Inservice	August 31st	Closed
September	Teacher Inservice	September 1st	Closed
	Labor Day	September 4th	Closed

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

NAME_____

BIRTHDATE_____

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

- ☐ Allergies (food, medicine, bee sting etc.)
- ☐ Constipation/Diarrhea
- ☐ Frequent Colds
- ☐ Hearing Difficulty
- ☐ Seizures
- ☐ Fainting
- ☐ Speech Difficulty
- ☐ Vision Difficulty
- ☐ Physical Handicap
- ☐ Behavior Problem
- ☐ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

_____

_____

Parent/Guardian's Signature_____ Date_____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: _____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's Signature_____ ☐ M.D. ☐ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

DOC.NO. 37-06-10-01-01-01

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PERMISSION TO PHOTOGRAPH FORM

I, _____
(Parent's or Guardian's name)

give permission for _____
(Name of Child Care Provider)

to photograph my child/ren _____
(Child's Name)

For the following purposes:

Type of Use:	(Please check one)	
	Grant Permission	Decline Permission
Still photographs:		
Display in provider's personal scrapbook		
Give photographs to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on facility's website *		
Use still photos in promotional materials		
Videos:		
Give video to current parents		
Display video on facility website		
Use videos in promotional materials		
Other (please list):		

* Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment. By signing below, I also agree that this is a legally binding form, and providing false information could be grounds for termination of childcare services, forfeiture of retainer, or both.

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

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Alternate Nutrition Plan

Parents are responsible for notifying the facility of their child's modified diet, and all allergies. This record will be signed by the parent and the director and kept on file. Please list below your child's modified diet plan.

Child's name: _____

Child's diet plan is as follows: _____

Child is allergic to the following items: _____

_____

_____

I understand that I am responsible for supplying the items needed to fulfill my child's modified diet plan.

Parent's Name: _____

Parent's Signature: _____

Date: _____

****Please note: This is only for those children who are allergic to specific foods or has any dietary restrictions. Only complete this form if your child(ren) fall under this category. All other children will be given full meals as part of our Food Program.****

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Permission for Food-Related Activities & Special Occasion Food Consumption

Licensed childcare facilities must obtain written permission from parents/guardians regarding a child's participation in food related activities. These activities include such things as: classroom cooking projects, gardening, school wide celebrations, and birthdays.

I _____ give/decline permission for my child _____
(Parent or Guardian) (Child's Name)
to participate in food related activities and special occasions where food is consumed.

Please provide the following information:

_____ My child DOES NOT have a food allergy or dietary restriction. He or she may participate in activities.

_____ My child DOES NOT have a food allergy or dietary restriction. He or she MAY NOT participate in activities.

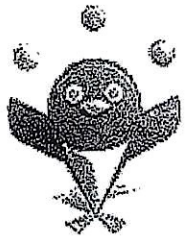
_____ My child DOES have a food allergy or dietary restriction. He or she may participate in activities, but may not eat or handle the following items (please list below):

_____
_____
_____

_____ My child DOES have a food allergy or dietary restriction. He or she MAY NOT participate in activites.

I understand that it is my responsibility to update this form in the event that my decision for permission changes. I agree that this form will remain in effect during the term of my child's enrollment.

Parent or Guardian Signature: _____ Date: _____



myprocare®

Dear parent/guardian,

Brilliant Little Minds is pleased to offer **MyProcare,** a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with Brilliant Little Minds) and choose ***Go.***

3. Enter the confirmation code sent to your email, choose a password, and press **Go.**

4. Then you may:.
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card.

Thank you!

Brilliant Little Minds and MyProcare

(★) No fees to use this

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** 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. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

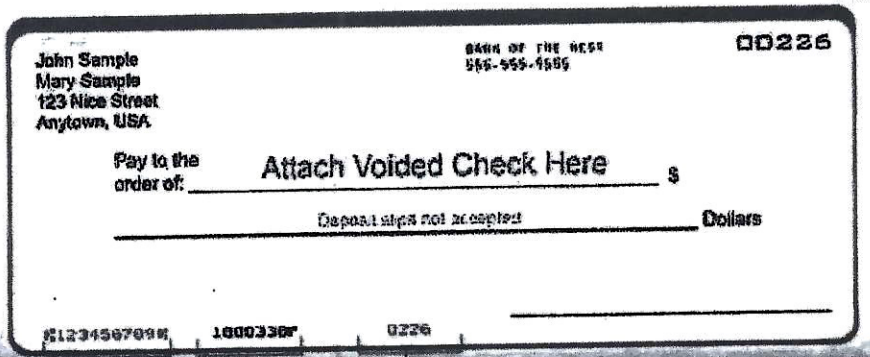
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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(*) Processing company charges 2% transaction fee

Tuition Express®

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 from your bank account.

AUTHORIZATION FOR CREDIT CARD

I (we) hereby authorize _____ 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 Representative for a list of Credit Cards Accepted as Payment.

_____ _____
Cardholder Name | Phone #

_____ _____ _____ _____
Cardholder Address | City | State | Zip

XXXX-XXXX-XXXX-____ _____
Credit Card Number (Last 4 Digits ONLY) | Expiration Date

_____ _____
Signature | Today's Date

☐ Check if you wish to make online payments

A service of

procare SOFTWARE®

For Official Use Only...

_____
Date Received

_____
Employee Signature

- < Cut Here > -

_____ _____
FULL Credit Card Number | Expiration Date

_____
Today's Date

For Security, please...
☐ return this Section of the Authorization Form.
☐ Shred this Section of the Authorization Form.