

BEFORE & AFTER CARE @ LOREWOOD GROVE ELEMENTARY

- * Breakfast & Snack included
- * Accepts POC+
- * Appo Employee Discounts
- * Drop in care available for enrolled students when school is closed.
- * Planned activities & fun things to do

www.brilliantlittleminds.com

Brilliant Little Minds Learning Academy

NOW ENROLLING!

September 2023 Fall School Year
6:30 am to 6:00 pm

To enroll: Fill out forms on website,
scan and email

blm.middletown@gmail.com
Main Location
102 Sandhill Dr
Middletown, DE 19709

For more information contact us at
(302) 376-9889

VISIT OUR WEBSITE FOR ENROLLMENT INFO

LOREWOOD GROVE ELEMENTARY

2023-2024 School Year Before and After Care
At Lorewood Grove Elementary
Provided by Brilliant Little Minds

Program Costs:

| | |
|-------------------------|---|
| Before & After Care | \$145/week |
| Before Care | \$110/week |
| After Care | \$100/week |
| Appoquinimink Employee | 25% off tuition (must provide current ID badge) |
| Sibling Discount | 5% off of one child with lowest tuition |
| Drop in Care | \$40/day * (please see drop in care below) |
| 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
- To withdrawal from this program you must give a 30 day notice in an email to the main location
- There will be a drop in (Appo schools are closed) schedule and form to fill out per drop in day, certain dates will be available and based on a first come first served bases. Once signed up then no refunds will be given. Once the school year gets started we will provide those dates available.
- 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

LOREWOOD GROVE ELEMENTARY Before/After Care Hours

Before Care: 6:30-9:05 am

After Care: 3:45- 6:00 pm



New Enrollment Deposit Form
Lorewood Grove Elementary School
Before/After Care Program

Name of child: _____ Date Received: _____

Date of Birth: _____ Grade: _____

Name of Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

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 last week of school = equal to one week tuition)

\$_100_ - Registration fee

\$_____: TOTAL deposit due (Add up totals 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) do not start within 2 weeks of the agreed upon date, that 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 locations. Weekly tuition must be setup on auto pay.

Signature of Parent/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**

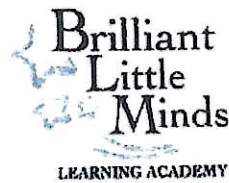
I, _____, the parent (or legal guardian) of _____, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

 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.



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.

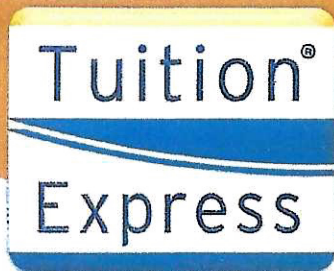
Start Date: _____ School and Grade: _____ Choose one: Before / After / Both

Parent/Guardian (1) Signature: _____

SS# _____

Parent/Guardian (2) Signature: _____

SS# _____



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) Brilliant Little Minds 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 _____

John Sample
Mary Sample
123 Nice Street
Anytown, USA

BANK OF THE NEST
555-555-5555

00226

Pay to the order of: Attach Voided Check Here \$ _____

Deposit slips not accepted _____ Dollars

12345678901 1800338 0226

Routing Number Account Number Check Number

A service of



procure
SOFTWARE®



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?

**STATE OF DELAWARE
DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE LICENSING (OCCL)**

NAME _____

Family Child Care Home
Large Family Child Care Home
Day Care Center
Youth Camp

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

| | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies (food, medicine, bee sting etc.) | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Fainting | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Behavior Problem |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision Difficulty | <input type="checkbox"/> 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

| | | | | |
|--------------------------------------|---------------------------------|--------------------------------------|---|---|
| <input type="checkbox"/> Scalp, Skin | <input type="checkbox"/> Heart | <input type="checkbox"/> Vision | <input type="checkbox"/> Ear, Nose | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Throat | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Genitalia | <input type="checkbox"/> Teeth | <input type="checkbox"/> Extremities | <input type="checkbox"/> Neck, Glands | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Height | <input type="checkbox"/> 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 Polysaccharide 1 / / | 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 / / | Lead Screening 24 mo / / |

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

Printed Name: _____ Telephone: _____

Brilliant Little Minds

LEARNING ACADEMY

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 |

Brilliant Little Minds

LEARNING ACADEMY

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.****

Brilliant Little Minds

LEARNING ACADEMY

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 activities.

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: _____

Child's Name _____

PARENTS RIGHT TO KNOW AND PERMISSIONS



PARENTS RIGHT TO KNOW NOTICE

Per the Delaware code, you are entitled to inspect the active record and complaint files of any licensed child care facility. To review a record contact: the administrative specialist, Office of Child Care Licensing, 3411 Silverside Road, The Concord | Hagley Building, Wilmington, Delaware 19810, phone (302) 892-5800. You may also view substantiated complaints and compliance review histories for the past five years by visiting the Office of Child Care Licensing's child care search at https://education.delaware.gov/families/occl/child_care_search/.

I acknowledge I received this notice as part of the application packet.

Parent/Guardian Signature

Date



PARENT PERMISSION FOR SCREEN TIME USAGE

Children over the age of two may have an educational video, movie, or game incorporated into their curriculum. These may be viewed on a television, computer, tablet, or gaming device. These will be age-appropriate and limited to one hour per day unless a special occasion or activity occurs. Children will be closely supervised while using the internet.

I hereby authorize my child to have screen time activities.

Parent/Guardian Signature

Date



PARENT PERMISSION TO SLEEP ON A MAT

Children between the ages of 12 and 18 months will be transitioned from sleeping in a crib to a cot, mat, or bed when they are able to walk.

I hereby authorize my child to sleep on a cot, mat, or bed.

Parent/Guardian Signature

Date