LITTLE SCHOLARS SCHOOLS

"Where LOVE Stimulates LEARNING, and LIFE-LONG LEARNERS Develop POTENTIAL"

Little Scholars Learning Center & Elementary

8707 Stanton Road
Little Rock, AR 72209
Tel (501) 562-2774
www.littlescholarsschools.org

WELCOME TO LITTLE SCHOLARS SCHOOLS

Thank you for considering us to care for your child.

➔ **The following must be submitted BEFORE enrollment:**

- **Child's birth certificate**
- **Child's social security card**
- **Child's current immunization record.**
- **State issued Driver's License or ID. of all adults on the Applicant's Personal Data Sheet**
- **$75 (per child) Non- refundable Registration Fee** *(unless applicant is a drop-in, on TEA or Foster Care Vouchers)*
- **First week's tuition**
- **Tuition Express Autopay Form** *(Payment by credit or debit card only.)*
- *Also, be on the lookout for an invitation to the Procare App shortly after your enrollment.*

➔ **Enrollment Package: All pages must be read and completed:**

- **Little Scholars Schools' Enrollment Agreement**
- **Consents and Acknowledgements**
- **Applicant's Personal Data**
- **Medical Information**
- **Child's Developmental Needs**
- **HIPPA Release / Getting to know you**
- **Transportation Permission Form *(for preschool and above)***
  - **Acknowledgement of Shaken Baby and Kindergarten Readiness Info**
- **Receipt of Handbook signature page**
- **Child Care Food Program Enrollment Form *(DO NOT SKIP!)***
  - **CACFP Meal Benefit Income Eligibility Form (*part 1 - 2 PAGES*)**
  - **CACFP Meal Benefit Income Eligibility Form (*part 2 - 2 PAGES*)**
  - **Obligation to Serve Infants** *(only if you are enrolling an infant up to 12 months old)*

FOR ADMINISTRATIVE USE ONLY		
Class Assignment:	Actual Start Date:	Last Day:

LITTLE SCHOLARS SCHOOLS' ENROLLMENT AGREEMENT

Effective January 1, 2023 until superseded

Student Information		Parent/Guardian Information	
Name:		Name:	
Date of Birth:		Date of Birth:	
SSN #:		SSN #:	

What date would you like to start?_____

LITTLE SCHOLARS SCHOOLS' MISSION

MISSION STATEMENT

Little Scholars Schools provides a safe, nurturing, and developmentally appropriate program which fosters active learning, support for the whole child, and a child-friendly environment. LSS mission is to admirably serve families of the Greater Little Rock community, many of which are financially challenged and resource-limited, by providing their children with quality care, excellent programming, and superior academic services, at affordable prices.

Little Scholars Cultural Standards

- Our Children come first!
- Our Employees are accountable for children's achievement that meets or exceeds state standards.
- Our Employees will demonstrate respect, concern for others, and integrity.
- Our Children's success is the only choice.
- Our Communication is open and productive.
- Our Children, parents, families, and community members are essential.
- Our center respects and appreciates diversity.

VISION STATEMENT

The vision of LSS is to ensure that Greater Little Rock children, regardless of their families' economic status, enter kindergarten prepared to succeed.

MOTTO

"Love stimulates learning."

PARENT/GUARDIAN'S DECLARATIONS

- I acknowledge the receipt of LSS' Parent Handbook and on behalf of my child, I accept the standards, regulations, and policies set forth therein. My attention has been called to LSS' Behavior Modification Policy and the methods which, if necessary, may be employed to modify the behavior of my child. I give my permission for the use of any age-appropriate methods set forth therein, if they are deemed necessary.
- I give permission for the applicant to take part in all school activities, some of which may necessitate trips off the school grounds, and absolve LSS from liability to the applicant or me, if an injury to the applicant should occur. I understand that advance notification will be given of off-campus activities.
- I have been given a copy of the current tuition and fee schedule. I agree to pay on time all charges resulting from the placement of the applicant at LSS, be the charges admission or tuition-related, occasional, or miscellaneous fees.
- I understand that I am required to give a written 1-week (7 days) notice of the applicant's disenrollment to avoid additional tuition charges (A disenrollment form may be obtained from reception). Parents/guardians having vouchers are assumed to have withdrawn their children when their voucher expires, unless LSS is notified one (1) week in advance that the parent/guardian agrees to pay for additional service.
- I understand drop-off time is no later than 9:50 am for all students on all days unless a note from a doctor or DHS is provided.
- I understand that the charge for late pick-up ($1/minute) will be charged to my account and will be notified
- I understand that per DHS regulations my child may attend more than 10 plus hours
- I understand that LSS will try diligently to prevent the damage or loss of the applicant's personal items, be they clothing, jewelry, or other; however LSS cannot be monetarily responsible for high value items, such as "designer" clothing, jewelry, or collector's items.
- I understand that if damage beyond normal wear and tear is done to LSS' facilities, equipment, books, and/or materials by the applicant, I will be held monetarily responsible.
- I understand that the applicant's enrollment is a privilege, which may be forfeited, if the applicant or parents/guardians do not conform to the standards, regulations, and/or policies of LSS.
- I also understand that the applicant's academic progress is highly dependent on minimizing student absences and tardiness, especially during the morning hours when class work is most rigorous. The one student that LSS cannot teach is the one who is not in attendance!

I have read, understand, and agree to abide by the above enrollment terms.

Date:____/____/____ Parent/Guardian's Signature: _____

Consents and Acknowledgements

	INITIAL BELOW:	
Licensing		**Per DHS requirements, the State of Arkansas has the right to interview my child at Little Scholars Schools at any time.**
Sunscreen		**I hereby give written permission for the application of sunscreen lotion or spray on my child in sunny weather.**
Immunization		**I hereby authorize Little Scholars Schools to obtain the Immunization Records for my enrolled child.**
Media: Electronics **(Media release is optional.)**		**I give Little Scholars Schools permission to use my child's photography or video footage on the school website and social media.**
Media: Marketing		**I give Little Scholars Schools permission to use my child's photograph or video footage in marketing/public relations.**
Media: Newsletters, Yearbooks/ School Publications		**I give Little Scholars Schools permission to use my child's photograph or video footage in the Little Scholars Schools Newsletters, Yearbooks and School Publications**
Media: Classroom		**I give Little Scholars Schools permission to use my child's photograph or video footage in classroom crafts.**
Media: School Performing Events		**I give Little Scholars Schools permission to use my child's photograph or video footage in school performance or graduation slideshow/recordings.**
Documents		**I have received information about Carter's Law (Shaken Baby Syndrome), Kindergarten Readiness, and ARKids First. (See the end of the handbook that you have been provided. A copy of this handbook is also available to you for the duration of your enrollment by request via paper copy and/or email.)**

Guardians of foster children: Foster children are exempt from any and all media consents and activities above mentioned.

I, the parent/guardian of this child, have read and understand the consents and acknowledgements stated above.

Date:____/____/____ Parent/Guardian's Signature:_____

APPLICANT'S PERSONAL DATA

Child'sName:_____DOB:____/____/____

Desired Placement Date: ____/____/____ Proposed Placement Date: ____/____/____

Mother/Guardian's Name:_____ Home Phone:___-___-____ Cell: ___-___-____

Home Address:_____

City:_____ State:_____ Zip:_____

Marital Status: (Circle one) Married Single Divorced Other_____

Employer: _____ Work No: (____) _____ Work Hours:_____

E-mail Address:_____

Newsletters, important notes, and other information may be e-mailed

Would you like to receive important notifications via text Message? ***(Circle one)*** **Yes No**

Father/Guardian's Name:_____ Home Phone:___-___-____ Cell: ___-___-____

Home Address:_____

City:_____ State:_____ Zip:_____

Marital Status: (Circle one) Married Single Divorced Other_____ Employer:

_____ Work No: (____) _____ Work Hours:_____

E-mail Address:_____

(Newsletters, important notes, and other information may be e-mailed

Would you like to receive important notifications via text Message? ***(Circle one)*** **Yes No**

Emergency Contact Information

Name of Person to call, if parents cannot be reached:_____ Relationship to child _____ Phone (___) _____ Home Address:_____ City:_____ State:_____ Zip:_____

Is this Person authorized to take this child from Little Scholars? ***(Circle one)*** **Yes No**

Pickup/drop off Consent

List all other adults who are authorized to drop off and/or pickup the child from Little Scholars Schools:

Name_____ _____
Phone_____ _____
Relationship_____ _____

Program:

(Circle one) **Full Time (5x) Part Time** ***(Circle one)*****: 4xwk 3xwk 2xwk 1xwk Drop-In Aftercare**

Date:____/____/____ Parent/Guardian's Signature:_____

Medical Information

Emergency Treatment Facility: _____

EMF Address_____ EMF

City_____ Child's

Physician_____Phone No (____)_____

I, _____, Parent/Guardian of_____, do hereby give my consent to the Director of Little ScholarsSchools, or his duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency, when the parent(s) cannot be reached in a reasonable length of time. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if a parent or Mobile Emergency Medical Service vehicle cannot respond promptly. I hereby **give_____/do not give_____** the Director of the Child Care Facility or his appointed representative permission to give my child acetaminophen. I understand I will be notified that the medication has been administered.

Signature_____ Date_____/_____/_____

Disease History *(if any)* List the dates of each:

Measles_____/_____/_____ Mumps_____/_____/_____ German Measles_____/_____/_____ Chicken Pox_____/_____/_____ Whooping Cough_____/_____/_____

Does your child have Asthma or Allergies? Yes No (if yes, please specify)_____

Contracted Tuberculosis: Yes No

Frequent Ear Infections Yes No

Frequent Throat Infection Yes No

Defective Heart Yes No Other Conditions or comments_____

Child's Insurance Provider / Policy Number: _____

If your child does not have health insurance, ask administrative personnel for information about ARKids First.

ARkids First health insurance is a program provided by the Arkansas Department of Human Services. This program has two coverage options to provide medical benefits to Arkansas children. You can request an application by calling 1-888-474-8275, stopping by your local DHS office, or by going to https://access.arkansas.gov/Welcome.aspx. To learn more about these programs go to http://www.arkidsfirst.com/home.htm for more information.

Child's Developmental Needs:

Please identify ALL physical or emotional concerns:

Temper Outbursts _____ Diabetes_____ Frequent colds_____ Biting_____ Sun sensitivity_____ Seizures_____ Fainting Spells_____

Bed wetting_____

Disabilities_____

Help dressing _____ undressing ___ toileting ____ feeding self ___ washing hands ____

Favorite Games:_____ Favorite Toys:_____

Favorite Story:_____ Favorite Foods:_____

Any Food Allergies/restrictions: _____

Medication(s): _____

Are there other siblings here? Yes No Number/Name _____

of siblings: _____

Prior Child care? Yes No

Type of child care used before _____

Other useful information _____

Can your child participate fully in LSS' physical education program?_____

HIPAA Release Form - Allergy and Medical Postings:

I, (print name)_____, parent/guardian of _____ authorize the Center to post my child's allergy/medical alert in his/her assigned classroom, in the kitchen, and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

(Signature)_____ (Date)_____

Getting to know you and your family:

Is your child looking forward to his/her attending the Center? ***(if applicable)***: _____

Do you anticipate any apprehension about entering the Center? _____

Tell us about the family pet***(if applicable)***: _____

When your child is upset or unhappy, what seems to comfort him/her?

_____

Does your family celebrate holidays? Yes No Please list your family's revered holidays:

_____

What is/are your family's religious affiliation(s)?_____

What are your short term and long term goals for your child?

_____

What are some things you hope your child will learn while in our program?

_____

What languages do you speak with your child at home? _____

Is there any important information you would like to add?

_____

I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature _____ Date _____/_____/_____

CONSENT FOR EMERGENCY MEDICAL CARE

I ,_____, _____ of
_____ (Parent/Guardian's Name) (Relationship to Child)
(Child's Name)
do hereby give consent to the Director of Little Scholars Schools or his duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when a parent cannot be contacted in a reasonable length of time. Consent is also given to the Director or his duly appointed representative to transport said child for emergency medical treatment, if a parent or MEMS vehicle cannot respond promptly.

Child's Physician or emergency treatment

facility_____ Address_____

City_____Phone _____

_____ ____/____/____
Parent/Guardian Signature Date

_____ ____/____/____
Witness Date

Acknowledgement of Receipt

TRANSPORTATION PERMISSION FORM

My child will be able to take a field trip depending on their age. Guardian will receive a permission slip prior to the field trip.

SIGNATURE:_____
DATE: _____

I have received the **SHAKEN BABY INFORMATION SHEET**:
He recibido la HOJA DE INFORMACIÓN SHAKEN BABY:

SIGNATURE:_____
DATE: _____

I have received the **KINDERGARTEN READINESS CALENDAR**:
He recibido el CALENDARIO DE PREPARACIÓN PARA KINDERGARTEN:

SIGNATURE:_____
DATE: _____

This information is included in the handbook you received with this enrollment package.

SIGNATURE REQUIRED

PLEASE SIGN THIS PAGE AND TURN IN TO THE ADMINISTRATION OFFICE

READ THIS DOCUMENT CAREFULLY BEFORE YOU SIGN!

BY SIGNING THIS DOCUMENT, YOU AGREE AND UNDERSTAND THE POLICIES AND PROCEDURES INSTITUTED FOR STUDENT SUCCESS.

_____ (Parent\Guardian Signature) I have received a copy, read and reviewed this handbook with my child (ren) and agree to the terms and conditions found herein. I understand the expectations and agree to abide by the policies and procedures set forth herein by Little Scholars Schools.

CHILD CARE FOOD PROGRAM
ENROLLEMENT FORM

Provider's Initials: __________
Date: __________

To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information must be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have questions, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

Little Scholars Schools
Name of Day Care Facility

501-562-2774
Telephone #

8707 Stanton Rd
Address

Little Rock
City

AR
State

72209
Zip Code

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are specified below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ☐ AM Snack: ☐ Lunch: ☐ PM Snack: ☐ Supper: ☐ Late Snack: ☐

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	

Please identify any fool allergies or special needs your child(ren) require:

Doctor's Name: ______________________________ Doctor's Telephone: ____________________

Revised 07/2022

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.								
OPTIONAL **Participant's ethnic and racial identities**						**Please select all that apply**		
Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex (including gender identity and sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

EMERGENCY CONTACT INFORMATION:

Home Telephone #: _____ Work Telephone #: _____

_____ _____ _____ _____

Parent's Address City State Zip Code

Parent's Signature: _____ Date: _____

*Form expires one (1) year from this date

Revised 07/2022

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Little Scholars Schools

PART 1. NAME OF ENROLLED CHILDREN ***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes / No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐ ☐					
				☐ ☐					
				☐ ☐					
				☐ ☐					

ADDITIONAL HOUSEHOLD CHILDREN _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD:** _____

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

Name:	**Case Number**	
1. _____	_____	**NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.**
2. _____	_____	
3. _____	_____	

PART 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator ☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	

Updated 10/2021

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Little Scholars Schools **Page 2**

PART 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-__ __ __ __ **(required)** ☐ **I do not have a Social Security Number**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature:_____ Date:_____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".

HNP Representative Initials/Date (for use during CACFP Reviews)
_____

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Updated 07/2022

Building for
the Future

INFANTS ONLY
Obligation to Serve Infants in the CACFP

Dear Parents/Guardians:

This center/home/ministry participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infant and children. Participation in this program requires caregivers to follow specific meal patterns according to the age of the child being fed.
Policy requires a center/home/ministry participating in the CACFP to offer formula and meals to infants who are in care during meal service times. Parents/guardians, however, may decline what is offered, and supply the infant's meals instead.

Please complete the following information:

Name of Provider/Child Care Center: Little Scholars Schools

Type(s) of formula offered: Up to date list is available upon request with the Food Service Department.

Name of Infant_____

Birth date_____

o I accept the type(s) of formula offered by my provider/childcare center/ministry.

o I declined the type(s) of formula offered by my provider/childcare center/ministry.

□ I will provide _____formula/breast milk for my infant.

□ I will provide personal breast-feeding of my infant on-site at the facility.
Valid beginning October 1, 2017.

o I accept the meals and snacks offered by my provider/childcare center/ministry.

o I decline the meals and snacks offered by my provider/childcare center/ministry.

I will provide meals and snacks for my infant *(Circle one)*. Yes No

_____ _____ SIGNATURE OF PARENT/GUARDIAN DATE