



**Chenango Valley
NURSERY SCHOOL**

ENROLLMENT AGREEMENT 2025-2026

Sprouts Program (2 yrs. by August 1)

Completion of this agreement is required for enrollment.
This form will enable us to better understand your student and meet their needs.

ENROLLMENT INFORMATION				
STUDENT INFORMATION				
Child's First Name		Child's Middle Name		Child's Last Name
Child's Nickname				
Date of Birth	Sex	Child's Primary Language	Parent/Guardian/Sponsor Primary Language	
Child's Home Address			City	State
Zip				
School District You Presently Reside In:				
Class Preference: Mondays & Wednesdays Tuition: \$1,800/year (\$180/month)			AM 9:15-11:15	FULL <input type="checkbox"/>
			PM 12:45-2:45	<input type="checkbox"/>
Class Preference: Tuesdays & Thursdays Tuition: \$1,800/year (\$180/month)			AM 9:15-11:15	FULL <input type="checkbox"/>
			PM 12:45-2:45	<input type="checkbox"/>
*****MUST CHECK CLASSES IN ORDER OF PREFERENCE (1, 2, 3, 4) *****				
FAMILY INFORMATION				
Parent/Guardian/Sponsor		Relationship To Child		Home Phone
Cell Phone				
Home Address (If Different From Above)			City	State
Zip				
Home Email		Employer Name		Work Phone
Employer Address			City	State
Zip				
Work Hours				
Other Parent/Guardian/Sponsor		Relationship To Child		Home Phone
Cell Phone				
Home Address (If Different From Above)			City	State
Zip				
Home Email		Employer Name		Work Phone
Employer Address			City	State
Zip				
Work Hours				
STUDENT EMERGENCY CONTACT/RELEASE INFO (DO NOT INCLUDE PARENTS/GUARDIANS/SPONSORS LISTED ABOVE)				
Please notify CVNS if an Emergency Release Contact will pick up your child on a given day. For the safety of your child, we request that all authorized pick-up persons with whom staff is not familiar provide a photo ID at the time of pickup.				
Person 1		Relationship To Child		Home Phone
Cell Phone				
Home Address			City	State
Zip				
Home Email		Employer Name		Work Phone
Employer Address			City	State
Zip				
Work Hours				
Person 2		Relationship To Child		Home Phone
Cell Phone				
Home Address			City	State
Zip				
Home Email		Employer Name		Work Phone
Employer Address			City	State
Zip				
Work Hours				
Person 3		Relationship To Child		Home Phone
Cell Phone				
Home Address			City	State
Zip				
Home Email		Employer Name		Work Phone
Employer Address			City	State
Zip				
Work Hours				

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

PARENT INITIAL _____ STAFF INITIAL _____ DATE _____

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MEDICAL INFORMATION		
Child's Name	Date of Birth	
STUDENT DEVELOPMENTAL HISTORY		
Can your child verbally communicate their needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Can your child sit at the table for a snack?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Can your child walk up and down stairs independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Can your child sit for a short, simple story?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Is your child toilet trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
STUDENT MEDICAL		
Does your child have any special medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Does your child have any chronic illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Does your child have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please attach care instructions from your physician.
Does your child have asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please attach care instructions from your physician.
Does your child have any special dietary needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Is your child able to fully participate in all activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Does your child have any physical restrictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Does your child function at the level of other children in his/her age group?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain...
Please list a brief history of your child's serious injuries and hospitalizations.		
ALLERGIES (PLEASE LIST)		
Medication Allergies	Reaction	Food Allergies
		Reaction
Bee Stings Allergies	Reaction	Respiratory Allergies
		Reaction
Other Allergies	Reaction	Are any of these allergies life-threatening?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please attach care instructions from your physician for any life-threatening allergies.		
MISCELLANEOUS SCREENINGS & TESTS (PLEASE CHECK ALL THAT APPLY AND ADD THE DATE OF LAST SCREENING)		
Vision <input type="checkbox"/> _____	Developmental <input type="checkbox"/> _____	
Hearing <input type="checkbox"/> _____	Aptitude <input type="checkbox"/> _____	
Speech <input type="checkbox"/> _____	Educational <input type="checkbox"/> _____	
Other <input type="checkbox"/> _____		
Is your child currently receiving Early Intervention (EI) or CPSE Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?		

To the best of my knowledge the information contained above is accurate.

PARENT INITIAL _____ STAFF INITIAL _____ DATE _____

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MEDICAL INFORMATION CONTINUED				
Child's Name			Date of Birth	
STUDENT'S MEDICAL CARE PROVIDERS				
Primary Physician's Name		Primary Physician's Practice Name		Phone
Physician's Practice Address		City	State	Zip
Preferred Hospital/Clinic For Emergency Care		City	State	
Dentist's Name		Dentist's Practice Name		Phone
Dentist's Practice Address		City	State	Zip
CHILD'S IMMUNIZATION HISTORY (PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS)				
<p>Immunizations are required by our state. Below is a list of immunizations that your child may have received: Hepatitis B, Measles, Pneumococcal Disease, Varicella (Chickenpox), Diphtheria, Mumps, Polio, Tetanus, Haemophilus Influenzae Type B (Hib), Pertussis (Whooping Cough), Rubella</p> <p>Please attach a copy of your child's immunization records.</p>				
ADDITIONAL MEDICAL POLICIES				
<p>1. Prior to enrollment, I must provide CVNS with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.</p> <p>2. I agree to provide information to CVNS about my child's conditions, illnesses, allergies or other needs.</p> <p>3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.</p> <p>4. If my child becomes ill during his/her time at CVNS, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible after being contacted. If I cannot be reached, the staff will contact those listed in the <i>Child Emergency Contact and Release</i>.</p>				<p>INITIAL</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
EMERGENCY MEDICAL AUTHORIZATION & CONSENT				
<p>In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i>, and lastly my physician.</p> <p>In case of a medical emergency, I agree that my child may receive first aid and/or CPR.</p> <p>In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary, by paramedics or other emergency personnel.</p> <p>In case of a medical emergency, I will be responsible for the emergency medical expenses.</p> <p>In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.</p>				<p>INITIAL</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Your child's safety is our number one priority.</p> <p>Chenango Valley Nursery School will not release children from the program without the above information in writing.</p>				
Primary Parent/Guardian/Sponsor Signature			Date	

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RATE AGREEMENT, OTHER AGREEMENTS & CONTRACT APPROVAL

Child's Name	Date of Birth
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HOURS OF OPERATION

Regular operating hours are: AM Classes 9:15-11:15, AM Classes 12:45-2:45, except closings for various holidays, and inclement weather as described in the Parent Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of closures.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on Facebook as well as a notification on Remind. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

FEE POLICY

The first Sprouts payment of **\$180** is due **July 1, 2025** (you may also pay in full). Tuition is due first business day of the month by cash (please place in envelope w/coupon for tracking purposes) or check (made payable to Chenango Valley Nursery School). Checks can be mailed to: **Chenango Valley Nursery School, 740 River Rd, Binghamton NY 13901**

Tuition is not subject to discounts for holidays, emergency closures (i.e., weather, covid), or absence other than hospitalization, or absence at the request of a doctor (a written doctor's note is required to receive credit).	INITIAL
I agree to pay the full tuition in advance of services rendered.	
I agree to pay the full tuition fee even if my child is absent for one or more days.	
A late fee of \$10.00 is due if tuition is not received on time.	
A non-refundable registration fee of \$50.00 (\$15.00 for each additional child) is due yearly.	
Accounts more than two weeks in arrears may result in immediate termination of service.	
My child may have the opportunity to participate in a field trip that may have an additional fee due before the day of the event.	
All returned checks or ACH transactions (automatic debits) will be charged a fee of \$25.00.	
A month written notice is required for any child being withdrawn from the program.	
A receipt for income tax purposes <input type="checkbox"/> will <input type="checkbox"/> will not be provided.	

HANDBOOK ACKNOWLEDGEMENT

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Parent Handbook and agree to abide by them.	INITIAL
I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	
Information contained in the Parent Handbook may be subject to change.	

MEDIA RELEASE

Occasionally, photos are taken of the children at CVNS for use within our school, website, social media and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.	INITIAL

CONTRACT APPROVAL

I certify that I have read, understand, and accept all terms and conditions described in this **Enrollment Agreement**.

Primary Parent/Guardian/Sponsor Signature	Date	Staff Signature	Date
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