Child's Name: _____ Age: _____

Skagway Child Care Council
DBA Little Dippers Learning Center
PO Box 419, Skagway, Alaska 99840
(907) 983-2785

_____ Registration Checklist

(year)

Forms	Received
LDLC Agreement & Handbook Acknowledgement	
LDLC Child Information & Application	
Current Immunization Record	
Religious Exemption Form *(if applicable)*	
Child Release Authorization	
Child Emergency Information	
Field Trip Authorization	
Photo Release Authorization	
Transportation Authorization	
Topical Skin Products Authorization	
Signed Financial Agreement	
AutoPay *(if applicable)*	
CC49 *(if applicable)*	
First Month Calendar	
$25 per-child Registration Fee (cash/check)	
$150 per-family Deposit (cash/check)	

Addendum B: LDLC Agreement & Acknowledgment

Little Dippers Learning Center Agreement & Acknowledgment - FULL Enrollment

This Child Care Center Agreement sets out the Agreement for Little Dippers Learning Center ("LDLC"), located at 2203 Main St., Skagway, Alaska, to provide child care services for the below-listed child (herein, "Child") of _____ [Print Name of Guardian] and _____ [Print Name of Guardian] (herein together, "Guardian"): _____

Child's Name: _____ Date of Birth: _____

Terms and Conditions

1. Full-time / Part-Time AM / Part-Time PM [Circle One] child care services for Child will begin on _____ [Date].
2. The monthly tuition fee is $_____ [Fee], paid in advance and due on the 1st day of each month. Tuition is based on enrollment in full-time or part-time child care services, not attendance. Tuition is late if not paid by the 1st day of each month. A $50.00 late fee will be added to next month's tuition for late payment. Child will not be permitted to attend LDLC if payment is late. Checks for tuition will be made payable to LDLC and placed in the payment box located at LDLC. Guardian is jointly and severally liable for monthly tuition fees.
3. LDLC may increase the monthly tuition fee upon 30-day written notice to Guardian (monthly tuitions funded by government-prescribed rates require no prior notice).
4. There is no monthly tuition fee rebate for any reason.
5. Guardian may terminate this Agreement upon 30-day written notice to LDLC.
6. LDLC may terminate this Agreement without notice if the monthly tuition fee is a month late. LDLC may also terminate this Agreement, at LDLC's discretion, for the following reasons: (1) inability to meet Child and Guardian needs; (2) breach of this Agreement; (3) breach of LDLC Parent Handbook; and (4) aggressive behavior of Child, which poses a threat to other children or staff. If LDLC terminates this Agreement for the above reasons, monthly tuition payments will not be refunded.
7. The LDLC Parent Handbook is incorporated into and a part of this Agreement. LDLC may amend the terms and conditions of this Agreement and the LDLC Parent Handbook upon 30-day written notice to the Guardian.
8. Guardian warrants and represents that Guardian has read, understands, and agrees to be bound by the terms and conditions of this Agreement and the LDLC Parent Handbook.

X_____ _____ **X**_____ _____

(Parent/Guardian's Signature) (Date) (Parent/Guardian's Signature) (Date)

X_____ _____

(Administrator's Signature) (Date)

Child's Name: _____ Age: _____

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LDLC CHILD INFORMATION & APPLICATION

Date of Enrollment: _____

Child's Name: _____ Birth Date: _____
First Middle Last

Skagway Physical Address: _____

Local Mailing Address: _____

Phone: _____ Email: _____

Parent #1 Contact Information	**Parent #2 Contact Information**
Name: _____	Name: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____

Winter Contact Address: _____

Winter Contact Phone Number: _____

In case of emergency or illness and the parent/guardian above, Little Dippers may contact:

Emergency Contacts	Relationship	Phone #
1.		
2.		
3.		

HISTORY OF CHILD

PHYSICAL HEALTH

Are there any past or present health conditions of which Little Dippers should be made aware?
(Asthma, allergies, headaches, seizures, indigestion, etc.)

_____

_____

List any dietary restrictions or requirements for your child: _____

_____

List/describe any other information about your child's physical health (if necessary): _____

_____

DEVELOPMENTAL CHALLENGES/CONCERNS

Please check those which apply to your child.

☐ Difficulty hearing ☐ Difficulty seeing ☐ Difficulty walking, running or moving

☐ Difficulty with talking or making sounds ☐ Difficulty using his/her hands (such as puzzles, building with blocks, drawing, grasping)

If you checked any, please explain: _____

_____

DAILY LIVING

What are your child's regular eating habits? When are their snacks and meals?

_____

How does your child indicate bathroom needs?

Word for urination: _____ Word for bowel movement: _____

Special words for body parts: _____

Please describe any bathroom patterns or potty training practices relevant for the Little Dippers Staff.
(Bowel movement patterns, use of diapers, toileting equipment)

_____

What are your child's regular sleeping patterns? Awakens: _____ Naps:_____ Bedtime: _____

What help does your child need to get dressed? _____

How many hours per day does your child watch TV, videos, or play video games? _____

SOCIAL/EMOTIONAL/PLAY

What does your child enjoy doing most? _____

What are your child's favorite toys? _____

What age are your child's most frequent playmates? _____

How would you describe your child's personality? _____

What is the best way to discipline your child? _____

What is the best way to comfort your child? _____

Does your child use a special comforting item? _____

Describe any fears your child may have (Animals, loud noises, dark, storms, etc.): _____

_____

Does your child have any special interests? _____

Anything else you care to share with us:

_____ _____

Parent/Guardian Signature Date

Child's Name: _____ Age: _____

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Authorization to Release Child

The following person(s) are authorized to pick up my child from Little Dippers Learning Center.

Name	Relationship	Phone #
1.		
2.		
3.		
4.		
5.		

_____ _____

Parent/Guardian Signature Date

CHILD CARE LICENSING AND CHILD CARE ASSISTANCE PROGRAMS
Child Care Program Office

CHILD EMERGENCY INFORMATION

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57, Medical Administration regulations 7 AAC 10.1070, and/or Child Care Assistance regulations 7 AAC 41.

CHILD'S INFORMATION

*Child's Name:	*Date of Birth:
Siblings Enrolled? ❑ Yes ❑ No Name(s):	Any Custody Arrangements/Restrictions ❑ Yes ❑ No Special Instructions/Comments:

PARENT(S) OR LEGAL GUARDIAN(S) INFORMATION

*Name:	*Relationship:	Name:	Relationship:
*Cell Phone: Email Address:	*Home Phone:	Cell Phone: Email Address:	Home Phone:
Physical Home Address:		Physical Home Address:	
Place of Employment/Other:		Place of Employment/Other:	
*Employment or Other Main Phone:		Employment or Other Main Phone:	

PERSONS AUTHORIZED TO PICK-UP CHILD

List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations and/ or at other routine times.

Name:	Daytime Phone:	Cell:	☒ Emergency ❑ Routine
Name:	Daytime Phone:	Cell:	❑ Emergency ❑ Routine
Name:	Daytime Phone:	Cell:	❑ Emergency ❑ Routine
Name:	Daytime Phone:	Cell:	❑ Emergency ❑ Routine

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CHILD CARE LICENSING AND CHILD CARE ASSISTANCE PROGRAMS
Child Care Program Office

CHILD EMERGENCY INFORMATION

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CHILD'S INFORMATION

*Child's Name:	*Date of Birth:
Siblings Enrolled? ❑ Yes ❑ No Name(s):	Any Custody Arrangements/Restrictions ❑ Yes ❑ No Special Instructions/Comments:

PARENT(S) OR LEGAL GUARDIAN(S) INFORMATION

*Name:	*Relationship:	Name:	Relationship:
*Cell Phone: Email Address:	*Home Phone:	Cell Phone: Email Address:	Home Phone:
Physical Home Address:		Physical Home Address:	
Place of Employment/Other:		Place of Employment/Other:	
*Employment or Other Main Phone:		Employment or Other Main Phone:	

PERSONS AUTHORIZED TO PICK-UP CHILD

List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations and/ or at other routine times.

Name:	Daytime Phone:	Cell:	☒ Emergency ❑ Routine
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Name:	Daytime Phone:	Cell:	❑ Emergency ❑ Routine

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CHILD CARE LICENSING AND CHILD CARE ASSISTANCE PROGRAMS
Child Care Program Office

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57, Medical Administration regulations 7 AAC 10.1070, and/or Child Care Assistance regulations 7 AAC 41.

Child's Name:	Child Care Facility:

***Health Concerns**

❑ My child has no health concerns, including allergies or medications

-OR-

❑ My child has the following health concerns:

Medication, medical, or other treatments: _____

Allergies (including foods, drugs, other): _____

Additional Needs/Concerns (ex: dietary, health related services, special needs, behaviors) _____

Medication Administration Authorization Form on File (if applicable): ❑ Yes ❑ No

PREFERRED PHYSICIAN AND MEDICAL FACILITY INFORMATION

*Physician's Name:	Physician's Phone:
***Preferred Hospital:**	

I verify the information contained on this record is correct and complete. I hereby give the permission for emergency medical treatment, including emergency transportation to a health care facility, for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible, and that I will assume the costs associated with emergency medical care/transportation, if needed. I also understand it is my obligation to keep my child care provider informed of my whereabouts. This authorization remains valid until revoked by myself.

* _____ * _____

Signature of Parent or Legal Guardian Date Signed

***This information must be reviewed and updated by the child's parent at least semi-annually and when new information becomes available.**

Date & Initial		Date & Initial		Date & Initial		Date & Initial		Date & Initial	

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CHILD CARE LICENSING AND CHILD CARE ASSISTANCE PROGRAMS
Child Care Program Office

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57, Medical Administration regulations 7 AAC 10.1070, and/or Child Care Assistance regulations 7 AAC 41.

Child's Name: Child Care Facility:

*Health Concerns

❑ My child has no health concerns, including allergies or medications

-OR-

❑ My child has the following health concerns:

Medication, medical, or other treatments: _____

Allergies (including foods, drugs, others): _____

Additional Needs/Concerns (ex: dietary, health related services, special needs, behaviors) _____

Medication Administration Authorization Form on File (if applicable): ❑ Yes ❑ No

PREFERRED PHYSICIAN AND MEDICAL FACILITY INFORMATION

*Physician's Name: Physician's Phone:

*Preferred Hospital:

I verify the information contained on this record is correct and complete. I hereby give the permission for emergency medical treatment, including emergency transportation to a health care facility, for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible, and that I will assume the costs associated with emergency medical care/transportation, if needed. I also understand it is my obligation to keep my child care provider informed of my whereabouts. This authorization remains valid until revoked by myself.

* _____ * _____

Signature of Parent or Legal Guardian Date Signed

*This information must be reviewed and updated by the child's parent at least semi-annually and when new information becomes available.

Date & Initial | Date & Initial | Date & Initial | Date & Initial | Date & Initial

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Child's Name: _____ Age: _____

Skagway Child Care Council
DBA Little Dippers Learning Center
PO Box 419, Skagway, Alaska 99840
(907) 983-2785

Field Trip Authorization

We take the children on walking field trips to the Skagway Recreation Center, Skagway Public Library, Skagway Museum, Skagway Fire Department, Skagway School grounds (playground/community gardens), Molly Walsh Park, and short cart rides and walks close to the center. All other field trips not listed on this form will have their own, specific permission form.

_____ _____

Parent/Guardian Signature Date

Child's Name: _____ Age: _____

Skagway Child Care Council
DBA Little Dippers Learning Center
PO Box 419, Skagway, Alaska 99840
(907) 983-2785

Photo Release Authorization

With your permission, we may place your child's photo on our website, use it for advertising the facility or in the Parent Monthly Newsletter. Please fill out the form below to let us know your preference.

I, _____ the parent/guardian of _____,
(Parent's name) (Child's name)
GIVE permission for my child's picture to appear in the above mentioned media.

I, _____ the parent/guardian of _____,
(Parent's name) (Child's name)
DO NOT GIVE permission for my child's picture to appear in the above mentioned media.

_____ _____
Parent/Guardian Signature Date

Please know that we will be taking all children's photos for use in such things as art projects, screensavers, and classroom decorations within the facility

Child's Name: _____ Age: _____

Skagway Child Care Council
DBA Little Dippers Learning Center
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(907) 983-2785

Transportation Authorization

Little Dippers Learning Center:

My child _____ has permission to be transported, under the supervision of a designated Little Dippers employee, in the Little Dippers Van. My child will be in the appropriate child restraint for their weight and age range.

_____ _____

Parent/Guardian Signature Date

Child's Name: _____ Age: _____

Skagway Child Care Council
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(907) 983-2785

Topical Skin Products Authorization

I give Little Dippers Learning Center staff permission to use the following topical products on my child when necessary and as prescribed by the manufacturer on the product label.

☐ Sunscreen

☐ Hydrating Lotion

☐ Insect Repellent

☐ Bactine Spray

☐ I do not give permission for LDLC staff to use the products listed above on my child.

☐ I give permission for the LDLC staff to use the products on my child that I have provided.

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

Little Dippers Learning Center Financial Agreement 2025

I UNDERSTAND THAT: (Please initial on each line)

Registration Fees

_____ At the time of registration, I will pay a non-refundable registration fee of $25.00 per child. This fee must be paid before any space is reserved for your child. (**E-Payment or check only, no credit cards**).

_____ At the time of registration, I will pay a refundable $150.00 per family deposit, which will appear as a credit to my final bill. **(E-Payment or check only, no credit cards**)

Monthly Tuition

_____ I understand that per the LDLC Agreement & Acknowledgement, I am reserving a specific time slot for my child and that my child can only be present at LDLC between these previously designated selected times.

_____ I understand that I must give LDLC 30 days notice to disenroll my child or change my selected reserved space.

_____ I agree to pay my child's advance tuition by the 1st of each month.

_____I understand that my child will not be permitted to attend LDLC if advance tuition has not been paid by the 1st of the month.

_____ I will provide a completed monthly calendar with my child's intended schedule for the following month, no later than the 25th of each month.

_____ Revisions to the monthly schedule must be in writing to the Administrator as soon as possible, and will be approved based on the center's availability and staffing needs. Extenuating circumstances that alter your child's scheduled days will be addressed on a case by case basis. **Outside of the center's Illness Policy outlined in the Guardian Handbook,** frequent and/or last minute schedule changes are not guaranteed to be honored.

Other Charges

I will be charged:

- $1.00 each time that a Dipper diaper is used for my child.
- $20.00 each time Dippers must provide lunch for my child in case of a lost or forgotten lunch.
- $25.00 per day late pick up fee
- $40.00 NSF fee for each returned check
- $55 late fee for tuition payments made after the 5th day of each month.

Billing & Payments

I must abide by the following billing cycle and payment schedule:

_____Monthly tuition paid by the 1st of each month.

_____ I will be charged a **late fee of $55 against any outstanding balance** if my account is not paid by the 5th of the month.

_____ All accounts must be current in order for child to attend LDLC

_____ If my account is left unpaid for more than 30 days, I understand the Center will take legal action to collect any owed fees, interest, and penalties.

To help us streamline billing, please select from the billing options below:

RECEIPT OF BILL:
All invoices are sent electronically: Please provide the email address you would like to receive your monthly tuition invoices at:
_____

PAYMENT OF BILL:
_____ I want to pay **all** bills with the credit card information provided on the attached Auto Pay sheet (4% processing fee applies).

_____ I will pay **all** bills electronically via Wells Fargo bank transfer or Quickbooks payments

_____ I will pay **all** bills via check at the center. Cash is not accepted. **(CHECKS MADE OUT TO SKAGWAY CHILD CARE COUNCIL)**.

***Wells Fargo Banking Transfer:**
Parent pays via direct online transfer from your Wells Fargo account to Little Dippers Wells Fargo Account, with no added transaction fee.

How to setup WF online transfer and pay your bill:

1) Log on to your Wells Fargo Account, go to "Transfer & Pay", select "Send Money with Zelle"
2) Select Send
3) You'll need to add Little Dippers to your list by clicking on "+Add**"**
    a) Enter littledippersbilling@gmail.com
    b) Check "Add as Business"
    c) Business Name is "Skagway Child Care Council"
4) To pay your bill each month, log onto your Wells Fargo account, go to "Transfer and Pay", select "Send Money with Zelle", select your recipient (Skagway Child Care Council/Little Dippers), select your From account, and enter the amount you want to send.

CCAP

Families are encouraged to apply for the Child Care Assistance Program (CCAP) to help reduce childcare costs. To learn more visit: http://dhss.alaska.gov/dpa/Pages/ccare/default.aspx *Please see page 8 of the guardian handbook for more information*

_____ The Center will need to receive approval of Child Care Assistance directly from the State of Alaska.
_____ Qualifying families are responsible for, at a minimum, their monthly co-pay as determined by CCAP on their Authorization Form plus any remaining balance for hours of care.
_____ Parents are responsible for maintaining their CCAP authorization and will be financially responsible for their entire bill if there is a lapse in coverage or expiration.

I hereby promise to fulfill the financial obligations as described in order that my child may be enrolled in Little Dippers Learning Center:

Child's Name:_____ **Date of Birth:_____**

_____ _____
Parent/Guardian Signature **Date**

Child's Name: _____ Age: _____

Skagway Child Care Council
DBA Little Dippers Learning Center
PO Box 419, Skagway, Alaska 99840
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CREDIT CARD AUTO PAY

Little Dippers Learning Center offers the option to pay your bill automatically with your credit card. (MasterCard or Visa only) This application must be filled out completely in order to qualify. We will pre-authorize your credit card to ensure that it is valid. ***All information will be kept confidential.***

There will be a 4% processing fee added to your bill to cover fees and costs.

Name on credit card: _____

Credit card billing address (be sure to include zip code):

_____

Type (visa and mastercard only): _____

Credit card #: _____

Expiration date: _____ CVV (3 digits on back): _____

Your card will be automatically processed on the first day of each month (unless otherwise specified). Your credit card statement should show a charge from the Skagway Child Care Council.

_____ Please charge my credit card for all monthly child tuition (with added 4% processing fee).

I have read and agree to the following above policy and procedures.

_____ _____

Parent/Guardian Signature Date

ALASKA INCLUSIVE CHILD CARE PROGRAM

Division of Public Assistance
Child Care Program Office
3601 C Street, Suite 140
Anchorage, AK 99503

Office Use Only

SPECIAL NEEDS DOCUMENTATION

This form may be used to document your child's special need. Other forms may also be accepted to document your child's special need including: Individualized Education Plan (IEP); Individualized Family Service Plan (IFSP); medical diagnosis; or mental health evaluation completed and signed by a health care professional.

Health or Mental Health Care Professional Information

Printed Name of Practice, Clinic, or Agency, if applicable			
Printed Name and Title of Health or Mental Health Care Professional			
Address	City	State **AK**	Zip Code
Phone			

Child's Information

Printed Name of Child	Date of Birth
Printed Name of Parent or Legal Guardian	
Diagnosis or Description of Condition	
Specific Care Needs Related to the Above Diagnosis or Condition While in a Child Care Environment	
Specialized Training for Caregiver in a Child Care Environment, if Applicable	

Signature of Health Care Professional _____ Date _____