



Community Preschool Tuition Pricing and Enrollment Requirements

Please Note: ALL sections of the registration forms must be filled out completely in order to secure a spot for your child. We will not accept incomplete registration forms or those without the registration fee.

Enrollment Requirements

In order to register your child, the following items must be returned to Community Preschool.

- Registration Forms – signed and filled out completely
- \$125 **non-refundable** registration fee**
- Immunization Record showing your child is current on vaccines (or you may sign the “AR Dept. of Health Authorization to Disclose or Release Health Information” Form and we will get your child’s immunization record)

**All class availability is based on enrollment. Should we not be able to offer a class due to lack of enrollment for that age group, you will be notified as soon as possible and your registration fee will be refunded.

Program Hours

Our regular preschool hours are Monday – Thursday, 9:00 a.m. to 2:00 p.m.

Class Options

Children must be class age by August 1 of the current school year. Children enrolling in the 3- and 4-year-old classes must be fully potty trained. Those enrolling in the 4-year-old class may only choose the 4 day option.

- 4 day option: Mon/Tues/Wed/Thurs
- 3 day option: Choose 3 days from Mon/Tues/Wed/Thurs
- 2 day option: Mon/Wed or Tues/Thurs

Tuition and Fees

Yearly registration fee for all ages is \$125.00. Tuition is based on a yearly cost paid out in 10 monthly payments. First payment is due in August with the last payment due in May. Tuition will be prorated for any child enrolling after the school year begins. Prorated amount will be based on the number of school days remaining in the school year which may increase the amount of the monthly payment. Tuition is due no later than the 10th of each month. A late fee of \$25.00 will be added if paid after the 10th.

Regular monthly tuition (9:00 a.m. to 2:00 p.m.)

2 years old and up	2 days/week	\$1400/year (10 payments of \$140)
	3 days/week	\$2100/year (10 payments of \$210)
	4 days/week	\$2800/year (10 payments of \$280)
1-year-olds	2 days/week	\$1600/year (10 payments of \$160)
	3 days/week	\$2400/year (10 payments of \$240)
	4 days/week	\$3200/year (10 payments of \$320)

Discounts: We offer a 15% sibling discount on regular monthly tuition after the first child is enrolled at full price. Sibling discount does not apply to drop-in rates.

Shaken Baby Syndrome

Shaken baby syndrome is a type of inflicted traumatic brain injury that happens when a baby is violently shaken. A baby has weak neck muscles and a large, heavy head. Shaking makes the fragile brain bounce back and forth inside the skull and causes bruising, swelling, and bleeding, which can lead to permanent, severe brain damage or death. The characteristic injuries of shaken baby syndrome are subdural hemorrhages (bleeding in the brain), retinal hemorrhages (bleeding in the retina), damage to the spinal cord and neck, and fractures of the ribs and bones. These injuries may not be immediately noticeable. Symptoms of shaken baby syndrome include extreme irritability, lethargy, poor feeding, breathing problems, convulsions, vomiting, and pale or bluish skin. Shaken baby injuries usually occur in children younger than 2 years old, but may be seen in children up to the age of 5.

In comparison with accidental traumatic brain injury in infants, shaken baby injuries have a much worse prognosis. Damage to the retina of the eye can cause blindness. The majority of infants who survive severe shaking will have some form of neurological or mental disability, such as cerebral palsy or cognitive impairment, which may not be fully apparent before 6 years of age. Children with shaken baby syndrome may require lifelong medical care.

~ National Institute of Neurological Disorders and Stroke / National Institutes of Health

Immunization Requirements

All children enrolled in a licensed child care facility or early childhood education facility are required to have certain vaccines to attend unless an exemption has been granted by the state. You must provide your child's immunization record showing he/she is current on the required vaccines **OR** you may sign the "[AR Dept. of Health Authorization to Disclose or Release Health Information](#)" form allowing us to access your child's immunization record while they are enrolled in our center. If your child does not receive immunizations, you will need to provide an exemption from the state for the current school year. *Your child must be up-to-date on required vaccines by the first day of school (Aug. 21, 2017).*

Discipline Policy

We use a positive approach to discipline by re-directing behaviors or rearranging the environment to ensure good choices. If these steps are ineffective, an appropriate "time out" will be used. Time out will be for an age-appropriate amount of time, but will not be used for those under the age of 24 months.

Lunch Requirements

Your child will need a well-balanced, nutritious lunch each day which should include milk and an ice pack as we cannot refrigerate lunches. We also cannot heat lunches.

School Calendar

We generally follow the calendar of the Fort Smith School District for days off and inclement weather closings. First day of school is August 21, 2017.



9201 Dallas Street · Fort Smith, AR 72903 · (479) 452-9201 ext31 · fax (479) 452-9220

2017-2018 Registration Forms

In order to secure a spot for your child, ALL sections of the registration forms must be filled out completely. We must also have the non-refundable registration fee and immunization record.

Child's Information:

Child's Full Name _____ Gender _____ DOB _____
Home Address _____
City, State, Zip _____ Home Phone _____

Family Information:

Mother's Name _____ E-mail _____
Address if different from child's _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Occupation _____ Work Hours _____
Father's Name _____ E-mail _____
Address if different from child's _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Occupation _____ Work Hours _____

Name of your current home church _____ NONE

Days of the Week You Would Like to Register:** Please circle your choice of days. See brochure for corresponding tuition rates and class options.

Regular Program Hours: 9:00 am – 2:00 pm

- 2 day option: Mon/Wed Tues/Thurs
- 3 day option: Mon Tues Wed Thurs
- 4 day option: Mon - Thurs

***Class availability is based on actual enrollment. Non-refundable registration fee is \$125 per child. The only option for the PreK4 class is the 4 day option. Child will be placed in a class based on his/her age as of August 1, 2017.*

Enclosed is my registration fee of **\$125**. I understand that this fee is non-refundable. I am aware that the first tuition payment is due by the first day of school, which is **August 21**. I have read, and I am aware of the dangers of Shaken Baby Syndrome. I also understand that my child must be up-to-date on required vaccines by the first day of school, and I have supplied Community Preschool with a current immunization record for my child in order to complete registration.

Signature of Parent or Guardian

Date

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FOR OFFICE USE ONLY:	Shot record received? _____	Shots current? _____
Date Enrolled _____	Registration fee received _____	
Date Withdrawn _____	Age as of August, 1 st of current year _____	

COMMUNITY PRESCHOOL
Emergency Contact & Medical Information

Child's Full Name _____ DOB _____

Name your child goes by: _____

Father's Name _____ Work Phone _____ Cell Phone _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Emergency Contact Information

Name of person to call if parents cannot be reached: _____

Complete Address _____

Relationship to Child _____ Phone _____ Work Phone _____

Is this person allowed to take child from the center? Yes No

Authorization for pickup: List all other adults authorized to take child from the center.

Name Relationship to Child Phone

Name Relationship to Child Phone

Name Relationship to Child Phone

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**Medical Information & Authorization to Transport and Seek Medical Attention:**

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Complete Address \_\_\_\_\_

**Hospital preference** (circle one): Sparks Mercy No Preference

I, \_\_\_\_\_, Father, Mother, Guardian of \_\_\_\_\_, do hereby  
(your name) (circle one) (child's name)

give my consent to the Director of *CBC Community Preschool*, or his/her duly 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 parents cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment if the parents cannot be reached.

\_\_\_\_\_  
Signature of Parent or Guardian Date

\_\_\_\_\_  
Witness Signature Date

**Other Pertinent Medical and Developmental Information**

Disease History: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ German Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Whooping Cough \_\_\_\_\_

Seizures \_\_\_\_\_ Biting \_\_\_\_\_ Contracted tuberculosis \_\_\_\_\_

Heart Defect \_\_\_\_\_ Diabetes \_\_\_\_\_ Frequent Ear Infections \_\_\_\_\_

Sun Sensitivity \_\_\_\_\_ Frequent Colds \_\_\_\_\_ Frequent Throat Infections \_\_\_\_\_

Fainting Spells \_\_\_\_\_ Temper Tantrums \_\_\_\_\_

Please list any allergies, drug reactions, health problems, special needs, physical or emotional concerns, other pertinent medical history your child may have or any other concerns or comments. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_