Brentwood Early Childhood Center
Kristin Clemons
Director of Early Childhood Education

2350 St. Clair Ave., Suite B, Brentwood, MO 63144
Ph: 314-262-8521 • email: kclemons@brentwoodmoschools.org
@BECCDirector • ecc.brentwoodmoschools.org

Brentwood ECC Community,

Thank you for trusting us with the care and education of your young child for the upcoming school year. Our focus is always on the children: helping them develop, keeping them safe and happy, and supporting them as they endeavor their learning pathways. We look forward to serving the children and your family next year.

The Brentwood Early Childhood Center uses the Project Construct curriculum, which states that children actively construct their knowledge and values as a result of their interactions with the physical and social worlds. You will see student work displayed throughout the year on Twitter (@BECCDirector), on the walls/windows, through parent communications, classroom journals, and via videos we will share.

By April 1:
- ▢ Every family must complete **online registration through Infinite Campus**. Families new to our center will receive a registration link by March 1st via email. Returning families must log in to their Infinite Campus portal and review all family data for accuracy and make any necessary changes (such as adding a sibling or changing emergency contacts).

By May 1: <u>Email, Fax to 314-786-9437 or Drop Off in-Person:</u>
- ▢ **Proof of Immunizations** as per Missouri Law 210.003RSMo from your pediatrician's office. Drop them off or fax directly to: 314-786-9437; Exemptions require documentation from the St.Louis County Health Dept.
- ▢ **Annual Exam/Physical** dated 8/19/2023 or later using your pediatrician's form or the state's Child Medical Exam form.

By July 10:
- ▢ **Pay Tuition #1.** Tuition is billed over 10 equal installments. Log in to myprocare.com, return the ACH form for checking (no fee) or credit card (fee applies for credit card), or bring cash/check to BECC. Details on the Tuition Agreement page are in this purple folder.

By August 1: <u>Please Complete:</u>
- ▢ **Annual Student Health Survey**
- ▢ **Permission for Emergency Medical Care**
- ▢ **Technology Usage Form** (new families only)
- ▢ **Administration of Medication form** (If applicable)
- ▢ Complete the **Online Google Form** to be sent by your child's future classroom teacher on May 25.
- ▢ **Obtain a Gmail account** if you don't have one. Photo journals and other information sent throughout the year are in Google formats.

Please don't hesitate to contact us with your questions. We are here to serve your children and family and value a strong relationship with you.

Sincerely,
Kristin Clemons

Brentwood Early Childhood Center
Enrollment Selection (Monthly Installments/10 Equal Payments)
2024-2025

Child's Name (Last, First)	*Child's age on July 31 (Must be 2+ by July 31st)*	*Birthdate MM/DD/YY*

Parent's Name (Last, First)	*Parent's email*	*Parent's phone*

Street Address, City, State & Zip

***REGISTRATION DEPOSIT** * A non-refundable $100 Registration Deposit is due at the time of enrollment and is payable by cash or check. Please make checks payable to Brentwood School District.*

PRESCHOOL ENROLLMENT SELECTION - PLEASE INDICATE YOUR 1ST AND 2ND CHOICES BELOW						
Program Description	**Program Hours** *(subject to change slighty)*	**Days of Week**	**Age 2 Monthly**	**Age 3 Monthly**	**Age 4 Monthly**	**Indicate "1st" and "2nd" Choice**
Full Day	8:10 am - 3:10 pm	M-T-W-Th-F	$1,246	$1,038	$1,009	
Full Day	8:10 am - 3:10 pm	M-W-F	$760	$631	$615	
Full Day	8:10 am - 3:10 pm	T-Th	$593	$493	$479	
Half & Full Day Combination	8:10 am - 11:10 am M-W-F & 8:10 am - 3:10 pm T-Th	M-W-F Half Day & T-TH Full Day	$931	$732	$711	
Half & Full Day Combination	8:10 am - 11:10 am T-Th & 8:10 am - 3:10 pm M-W-F	T-TH Half Day & M-W-F Full Day	$1,043	$820	$795	
Half Day (AM)	8:10 am – 11:10 am	M-T-W-Th-F	$552	$461	$448	
Half Day (AM)	8:10 am – 11:10 am	M-W-F	$344	$285	$278	

INCOME-BASED FREE & REDUCED TUITION OPTIONS (REQUIRING ADDITIONAL APPLICATION)						
Half Day (AM)	8:10 am - 11:10 am	M-T-W-TH		REDUCED		
Full Day	8:10 am - 3:10 pm	M-T-W-Th-F		FREE	FREE	

NOTES:

- Tuition is determined by how old children are on July 31st and remains the same for the school year
- Full day tuition includes lunch and 2 snacks. Half day tuition includes 1 snack.
- Tuition is payable in 10 equal payments due on the 10th (July 10 - April 10). See Tuition Details in registration packet.

*Our registration fee offsets the cost of consumable supplies throughout the year. Reduced registration fee and tutition may apply if you qualify for the Free and Reduced Price Meals Program. Please contact the director for information.

Brentwood Early Childhood Center
2350 St. Clair Ave., Suite B, Brentwood MO 63144
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Brentwood Early Childhood Center
Before and After Care Selection (Monthly Rates)
2024-2025

Child's Name (Last, First)	*Child's age on July 31*	*Birthdate MM/DD/YY*

Parent's Name (Last, First)	*Parent's email*	*Parent's phone*

Street Address, City, State & Zip

EXTENDED HOURS - MONTHLY RATES

BEFORE CARE 7:30 AM - 8:05 AM		AFTER CARE 3:10-4:30	
SELECT DESIRED WEEKDAY	**MONTHLY COST**	**SELECT DESIRED WEEKDAY**	**MONTHLY COST**
☐ MONDAYS	$18	☐ MONDAYS	$37
☐ TUESDAYS	$18	☐ TUESDAYS	$37
☐ WEDNESDAYS	$18	☐ WEDNESDAYS	$37
☐ THURSDAYS	$18	☐ THURSDAYS	$37
☐ FRIDAYS	$18	☐ FRIDAYS	$37
TOTAL		TOTAL	

NOTE:

Our Before and After Care programs will be based on availability and are not guarenteed until confirmed by our Program Director.

Before Care and After Care costs will be included in your monthly tution bills that are payable in 10 equal payments due on the 10th (July 10 - April 10). See seperate document for Tuition Details.

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Brentwood Early Childhood Center
Tuition Details
2024-2025

TUITION DETAILS:

MONTHLY TUITION SCHEDULE	BILLING DATE	DUE DATE	LATE PAYMENT FEE ASSESSED
August	Jun 25	July 10	Jul 25
September	Jul 25	Aug 10	Aug 25
October	Aug 26	Sep 10	Sep 25
November	Sep 25	Oct 10	Oct 25
December	Oct 25	Nov 10	Nov 25
January	Nov 25	Dec 10	Dec 26
February	Dec 20	Jan 10	Jan 25
March	Jan 24	Feb 10	Feb 25
April	Feb 25	Mar 10	Mar 25
May	Mar 25	Apr 10	Apr 25

- Monthly tuition installments are nonrefundable.
- Students for whom payment is delinquent after the 25th of the month will be charged a $25 late fee
- If tuition is not paid in full on the 1st of the following month, the child will be removed from the program.
- There will be no tuition deduction for legal holidays, school district holidays or professional development days as they are built into the tuition structure. We follow the district calendar.
- The total cost of your child's annual program is divided into 10 equal payments.
- Missed days cannot be substituted for additional attendance days
- Tuition is not reimbursed for illnesses or quarantines

Please contact our Director, Kristin Clemons, should you have any questions regarding tuition payments.

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TECHNOLOGY USAGE
(Permission to Publish on the Internet-Student)

Online Tech Usage policy EHB:
https://simbli.eboardsolutions.com/Policy/ViewPolicy.aspx?S=437&revid=G9NfBjCvfQDMUplusjjNY2KHg==&PG=6&st=technology&mt=Exact

Consent

I do hereby give Brentwood School District the right to use my:

□ Yes □ No First Name

□ Yes □ No Photograph

□ Yes □ No Published Project (webpages, written work or other assignments)

□ Yes □ No Voice (for podcasting)

for reproduction on the internet. This material will only be used for activities related to the Brentwood School District's website.

Student's Signature: _____ Date: _____

Student's Printed Name: _____

Guardian's Consent If Student Is Under 18 Years of Age

I am the parent or the legal guardian of the above-named minor and hereby approve the foregoing and consent to the use of photograph, name, and published project and voice to the pursuant terms mentioned above.

I affirm that I have the legal right to issue such consent.

Parent Address: _____

Parent's Signature: _____ Date: _____

Parent's Printed Name: _____

This consent may be withdrawn at any time by contacting the Brentwood School District through written request.

Annual Student Health Survey

Enrollment for School Year: 20____- 20____

(Last)_____(First)_____(Middle)_____(Nickname)_____

Student's Legal Name Gender: ___Male ___Female Date of Birth: ___/___/___ Grade _____

Please circle any of the following conditions that affect your child, and use the space provided to give additional information you feel would be helpful in the care of your child (if your child requires medication to be taken at school, please see the school nurse for required documentation):

YES NO ADD/ADHD – Medication_____

YES NO Allergies (Specify)_____

(Medication)_____

YES NO Anxiety – Medication_____

YES NO Asthma – Medication_____

YES NO Autism/Asperger's Spectrum – Medication_____

YES NO Cancer_____

YES NO Depression – Medication_____

YES NO Diabetes – Medication_____

YES NO Heart/Lung Problems_____

YES NO Hearing Concerns/Ear Infections_____

YES NO Kidney/Bladder Problems_____

YES NO Major Illness/Injury – Specify_____

YES NO Orthopedic Issues_____

YES NO Seizures – Medication_____

YES NO Stomach/Bowel Problems_____

YES NO Surgery_____

YES NO Vision (Glasses/Contacts/Others)_____

1) Other than listed above, is your child currently taking any medication on a regular basis (prescription or over the counter)? If yes, what kind of medication and what is the reason for taking it? _____Dosage_____
2) Is your child currently under any kind of on-going medical treatment or care?_____
3) Will your child need Medical/Nursing care at school? If yes, please describe in detail.

_____

Please note that serious, life threatening health concerns will need a health care plan. Please contact your school nurse as soon as possible to schedule an appointment to complete this information. Additional Comments (please feel free to use the back of this form):

_____ _____

Physician Phone Number

_____ _____

Specialist Phone Number

_____ _____

Dentist Phone Number

Parent Signature: _____ Date: _____

PERMISSION FOR EMERGENCY CARE

Student Name _____ Date of Birth _____

Student Address/City/State/Zip _____

Mother's Name _____ Cell Phone _____

Work Number _____ Home Number _____

Father's Name _____ Cell Phone _____

Work Number _____ Home Number _____

If a parent cannot be reached, please contact a ***close relative*** or ***friend***:

Name _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone _____

Name _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone _____

Health Conditions/Allergies: _____

Current Medications: _____

_____

Epinephrine Permission: The school principal or designee will maintain a list of students who cannot, according to their parents/guardians, receive epinephrine. Please indicate your permission for the school to administer this:

Epinephrine: ☐ ***Yes***, I give permission to administer epinephrine ☐ ***No***, I do not give permission to administer epinephrine

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EMERGENCY AUTHORIZATION

To ensure the care of my child, I agree that pertinent health information may be shared with appropriate school staff, and may be forwarded to emergency medical personnel in emergency situations. I agree to notify the school nurse of any changes in medication or change in any health status of my child. I agree if any of the above information changes, I will notify the school immediately. I understand that in case of an emergency the school will first attempt to contact me. If I cannot be reached, I authorize the transport of my child to a hospital and authorize the physician or medical personnel to carry out any diagnostic procedures or emergency care deemed necessary. I will accept the full financial responsibility for charges connected with the use of an ambulance and charges connected with any medical necessary. I acknowledge that all foregoing above information is true and correct.

Parent/Guardian Signature _____ Date _____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

•BECC accepts this form or one from your doctor's office
•Include most recent immunization record
•These may be faxed by your doctor to:314-962-7302

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

FILE: JHCD-AF3
Critical

ADMINISTRATION OF MEDICATION TO STUDENTS

(Permission Form for Medications)

Note: Parent or Guardian MUST complete the entire form. NO over-the-counter or prescription medication will be dispensed unless provided in its original container. District practice allows administration of five doses of over-the-counter medication on a parent signature. Over five doses will require a physician's order/signature. All medication should be administered at home during non-school times if possible. The district will not knowingly administer the first dose of any medication.

School: _____ Date Form Received by the School: _____

Student: _____ DOB: _____ Age: _____ Grade: _____

Name of Medication: _____ Rx ☐ OTC ☐

Reason for Medication: _____

Form of medication: Tablet/Capsule☐ Liquid ☐ Inhaler☐ Nebulizer☐ Injection☐ Other: _____

Instructions: (Schedule/Times and Dose to be given at school): _____

Anticipated Side Effects: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Physician Name: _____ Phone: _____

Office Address: _____ Fax: _____

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PARENT PERMISSION FOR ADMINISTRATION OF ABOVE MEDICATION

I give permission for the administration of this medication at school. I give the district permission to contact the student's physician to provide information or to clarify administration instructions. I am responsible for providing the medication to the school and informing the school immediately of any changes. I release school personnel from liability should reactions result from giving this medication. In the event of an emergency I realize the student will be transported to the nearest appropriate health facility.

PARENT SIGNATURE: _____ Date: _____

Cell: _____ Work: _____ Home: _____

Notice: Stock pre-filled epinephrine auto syringes are located in each building and can be administered when available by the school nurse or other trained personnel in the event of a life-threatening anaphylactic emergency.

Implemented: 07/09/2003 Revised 3/21/2006; 12/12/2006; 4/16/2013; 12/10/2019 Brentwood School District, Brentwood, MO

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) _____ 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 _____

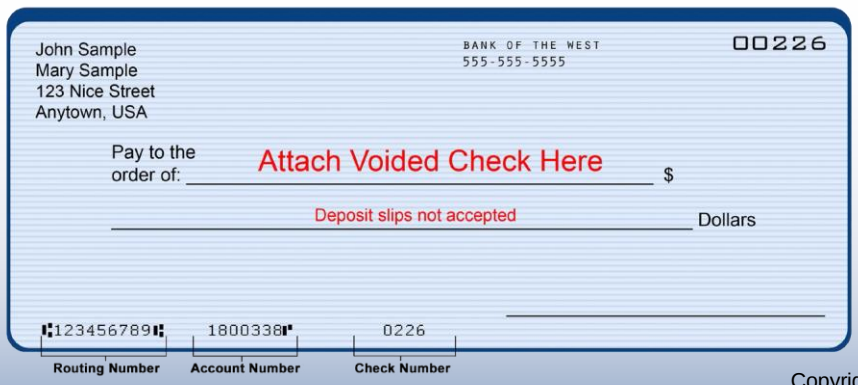
Bank or Credit Union Address _____ City _____ State _____ Zip _____

☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature



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