**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
Ph 314-262-8521

# 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.

**Brentwood Early Childhood Center**
2350 St. Clair Ave., Suite B, Brentwood MO 63144
Ph 314-262-8521

# 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.

**Brentwood Early Childhood Center**
2350 St. Clair Ave., Suite B, Brentwood MO 63144
314-262-8521

# 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

---

## 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: _____**

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

**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