Mount Cross Child Development Center

Admission Agreement

1. (a) All required forms including the Physician's Statement must be on file in our office prior to the child entering school. A pre-admission examination by your doctor is a state requirement. All children must have had immunizations prior to entrance.
   (b) At first sign of any illness, do not bring the child to school. First stages of a cold are particularly contagious. The student may return to school when she/he has had no temperature for 24 hours and is ready to participate in all school activities.
   (c) A child must be potty trained (or very close to it) before she/he is enrolled in school.
   (d) It is a State Law that each child must be signed in and out of school each day by a responsible adult.
   (e) The Department of Social Services has the authority to inspect and audit student and facility records without prior consent. This licensing agency has the right to observe the physical condition of children and interview children or staff.

2. A non-refundable registration fee is charged each year at the time of enrollment for every child. This is to cover insurance for the child and clerical expenses.

3. BASIC SERVICES – Mount Cross Child Development Center offers age-appropriate 3 hour programs 2-5 days a week. Lunch Bunch is offered five days a week until 1:30 PM. Early Birds is offered five mornings a week from 8:00-8:30 AM. (Please see handbook.)

4. The tuition is a flat monthly rate, regardless of illness, family vacation, or school holidays (including Christmas and Easter). Check with school office for current tuition rates. When two or more children in one family are enrolled, a 10% discount for each additional child is given. No credit is given for personal or school holidays. We also offer a military discount.

5. Please do not bring your child before the start of school. Also, please pick up your child promptly after school. If for some reason you will be late, please inform the school.

6. Label all possessions with your child's name. (Sweater, coat, lunch box, etc.)

7. Bring your child only on the days for which your child is registered.

8. If we feel our program is not meeting the needs of your child, we will conference with you and help you find an appropriate program.

9. Discipline is handled in a positive way at Mount Cross CDC, but if a child repeatedly hurts or threatens others, Mount Cross CDC reserves the right to discontinue the child's enrollment.

Child's name (please print) ____
Father's name (please print) ____
Mother's name (please print) ____

Parent's Signature ____

Director's Signature ____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Moms Cell____________

Dads Cell____________

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE	ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: ____________

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

______________________, born ______________________ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

Mt. Cross Child Dev. Center. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to ______ a.m./p.m. , __________ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

______________________ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

______________________ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Allergies: medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
____ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: ______________________
Address: ______________________
Telephone: ______________________

Date of Physical Exam: ______________________
Date This Form Completed: ______________________
Signature ______________________

☐ Physician ☐ Physician's Assistant ☐ Nurse Practioner

RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB.
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- Have, or are suspected to have, HIV infection.
- Live with an adult with HIV seropositivity.
- Live with an adult who has been incarcerated in the last five years.
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest X-ray suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Mt. Cross Child Development Center TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

______________________________ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME		DOES FATHER LIVE IN HOME WITH CHILD?
MOTHER'S NAME		DOES MOTHER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST ______
	DINNER	LUNCH ______
		DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s) or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME: Department of Social Services / Community Care licensing

ADDRESS: 6500 Hollister Ave. Suite 200, MS 29-09

CITY: Goleta, Ca.

ZIP CODE: 93117

AREA CODE/TELEPHONE NUMBER: (805) 562-0400

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY) Mt. Cross Child Development Center

(PRINT THE ADDRESS OF THE FACILITY) 102 Camino Esplendido Camarillo Ca 93011

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: ______________________

   Licensing Office Address: See "Personal Rights" form

   Licensing Office Telephone #: ______________________

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (12/06) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of ______________________, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Mt. Cross Child Development Center
Name of Child Care Center

______________________ Signature (Parent/Authorized Representative)

______________________ Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is http://ccl.dss.cahwnet.gov/RegionalOf_1329.htm

All CDC staff have fingerprints on file with the Department of Justice and have **NO criminal record**.

`Mount Cross Child Development Center - Photo/Name Release

As the Legal Parent (s) and/or Guardian of (see name listed below), who is enrolled in Mt. Cross Preschool, permission is granted to Mt. Cross Preschool and its Board members, employees, agents, servants and representatives to use this student's photographic likeness, alone or in a group, in any Mt. Cross Preschool publication or to release said photographic likeness to any newspapers, magazines for publicity and/or recognition purposes.
Additional, I extend this permission to use this student's photographic likeness, alone or in a group, on the official web site of Mt. Cross Preschool or a web site available through the official web site. The official web site is owned and maintained by the Church and School as a service to the parents, students and residents and can be viewed at: www.mountcrosscdc.com
I release Mt. Cross Preschool, its Board members, employees, agents, servants, representatives, and all organization and all individuals related to Mt. Cross Preschool's Internet Network from any and all liabilities or damages that result from the use of this student's photographic likeness on the official web site of Mt. Cross Preschool or of this student's name and/or photographic likeness to any newspapers or magazines for publicity and/or recognition purposes.
My permission shall remain in effect unless revoked by me and communicated to Mt. Cross Child Development Center in writing.

Child's name__________________ Effective Date______________

Parent signature___________________ Yes__ No__

Mount Cross Child Development Center

Financial Agreement

Please read, check off, and sign this agreement.

1. ☐ **I am aware of the scheduled school holidays and weeks the center will be closed as listed in the Parent handbook. I understand tuition is the same for all months (September – June).**

2. ☐ **I agree to the tuition rate of $__________ per month for 10 months including the month of June. If my child attends through May, I understand I still owe the last payment in June.**

3. ☐ **If my account becomes one month late, I understand my child will not be able to attend until payment is made.**

4. ☐ **If my child is sick and can't attend, I understand that I must still pay.**

5. ☐ **If my child is signed up for Lunch Bunch and I do not give notice of cancellation, I will pay for the Lunch Bunch session.**

Child's Name (please print) ____
Parent's Signature _________________________________Date _________

Parent Copy

Mount Cross Child Development Center

Financial Agreement

Please read, check off, and sign this agreement.

1. ☐ **I am aware of the scheduled school holidays and weeks the center will be closed as listed in the Parent handbook. I understand tuition is the same for all months (September – June).**

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4. ☐ **If my child is sick and can't attend, I understand that I must still pay.**

5. ☐ **If my child is signed up for Lunch Bunch and I do not give notice of cancellation, I will pay for the Lunch Bunch session.**

Child's Name (please print) ____
Parent's Signature _______________________________Date _________

School Copy

EnrollWithSmart.com
Visit www.enrollwithsmart.com now to complete this form faster!

Enroll Faster. Enroll Easier.
Enroll **SMART**er!

1 0 0 2 6 1 4 1 8 0 8

PLEASE ENTER FAMILY INFORMATION

FIRST NAME OF PARENT/GUARDIAN/BILL PAYER

LAST NAME OF PARENT/GUARDIAN/BILL PAYER

*FIRST NAME OF ADDITIONAL AUTHORIZED PARTY

*LAST NAME OF ADDITIONAL AUTHORIZED PARTY

STREET ADDRESS OR P.O. BOX

APT#

CITY

STATE

ZIP CODE

HOME TELEPHONE NUMBER

MOBILE TELEPHONE NUMBER

EMAIL ADDRESS (Smart emails reminders for upcoming payments)

SELECT A PAYMENT METHOD

☐ I agree to make payments by mail, web or telephone. I agree to the following due date: 01

Your school allows the following due date: 1

☐ I authorize SMART to automatically debit my payments from the below provided account. I agree to the following automatic payment date: 01

Your school allows the following due date: 1

PLEASE DEBIT MY: ☐ CHECKING (PLEASE ATTACH A VOIDED CHECK) OR ☐ SAVINGS

9 DIGIT ROUTING NUMBER

BANK ACCOUNT NUMBER

PLEASE CHARGE MY: ☐ AMEX ☐ DISCOVER ☐ MASTERCARD

CREDIT CARD NUMBER

EXPIRATION DATE /

A 2.65% convenience fee applies to all credit/debit card payments. Smart Tuition does not accept Visa.

SELECT A PAYMENT PLAN

Plan M 10 Payments Sep - Jun

ENTER PLAN LETTER HERE: M

ENTER STUDENT INFORMATION

Choose the following grade: PK

GRADE	FIRST NAME OF STUDENT	LAST NAME OF STUDENT

*OPTIONAL SCHOOL FAMILY ID:

*OPTIONAL TYPE CODE:

FOR SCHOOL OFFICE USE ONLY

☐ THIS FAMILY IS ENROLLING LATE:

☐ SPREAD BALANCE ACROSS REMAINING MONTHS OF PLAN

☐ COLLECT BALANCE IN FIRST MONTH

*OPTIONAL STUDENT ID		
	STUDENT TUITION 1	$.
	STUDENT TUITION 2	$.
	STUDENT TUITION 3	$.
	STUDENT TUITION 4	$.
	FAMILY TUITION SUBTOTAL	$.

PLEASE READ AND SIGN

I have read and agree to the terms and conditions on the reverse side of this document. I agree that the school may re-enroll me in the Smart Tuition payment program for each subsequent school year. I agree to pay the amount established by my school for the student(s) above by my specified due date. I realize that if I fail to have a payment posted or if there is an outstanding balance on my account by the specified due date, Smart Tuition may contact me via email and telephone and a late fee of $35.00 will be assessed to my account. A $30.00 fee will apply for any failed electronic transaction or dishonored check.

PRIMARY BILL PAYER ______________ DATE / /

FEES & DISCOUNTS

If fees and discounts should be applied in addition to the tuition amounts included above, please contact your account manager.

ANNUAL TOTAL DUE $.