



For office use only
 Enrollment Fee: _____
 Immunization Record: _____
 Copy of Insurance Card: _____
 Start Date: ____/____/____

THE WHOLE CHILD: ENROLLMENT PACKET

PLEASE NUMBER YOUR 1ST AND 2ND CHOICES OF PREFERRED PROGRAM DAY(S)

Program Days	Annual Tuition	10% Deposit
2 Day Option (3-5 year olds) _____ Monday, Wednesday _____ Wednesday, Friday _____ Monday, Friday	\$2,400	\$240
3 Day Option (3-5 year olds) _____ Monday, Wednesday, Friday	\$3,600	\$360

CHILD INFORMATION

Child's First Name: _____ Child's Last

Name: _____ DOB: ____/____/____

Age (as of Sept. 1, 2023): _____ Gender: _____ **CHILD INFORMATION**

Child's First Name: _____ Child's Last

Name: _____ DOB: ____/____/____

Age (as of Sept. 1, 2023): _____ Gender: _____

PARENT / GUARDIAN INFORMATION

1st Parent/Guardian

Name: _____

Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____

2nd Parent/Guardian (if applicable)

Name: _____

Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____

EMERGENCY CONTACT INFORMATION (Please provide 2 emergency contacts other than parent(s)/guardian(s) listed above).

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

PICK UP AUTHORIZATION

I give permission for the following people to pick up my child from Side By Side Studio, Inc. Until our staff becomes familiar with the individuals on the list, they will be asked to show a form of picture identification before your child will be released from our care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

MEDICAL INFORMATION AND AUTHORIZATION

Child's/Children's Name(s): _____

DOB: ____/____/____ Second Child's DOB: ____/____/____ **INSURANCE**

Name of Insured: _____

Relationship to enrolled child: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____

Name of Child's Physician: _____

Physician Address and Hospital Affiliation: _____

Physician Phone: _____

MEDICAL INFORMATION

Please list if any:

Chronic or recurring illness or medical conditions:

Dietary Restrictions:

Current medications:

Please list all allergies and/or health concerns:

MEDICAL RELEASE AND HOLD HARMLESS AGREEMENT

I (we), the parent(s), legal guardian(s), or custodian(s) of the child(ren) named in the application, knowingly release, absolve, INDEMNIFY, AND HOLD HARMLESS Side by Side Studio, Inc., as well as its employees, officers, directors, agents, representatives, affiliates, successors, and assigns from any and all causes of action of any kind whatsoever, whether in statute, contract, or tort (INCLUDING CLAIMS OF NEGLIGENCE), which in any way relate to or arise from the child's/children's activities at or sponsored by Side by Side Studio. In the event the child(ren) named in this application is injured while in the care of Side by Side Studio, Inc. and requires the attention of a doctor, I (we) consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event the treatment is called for which a physician and/or hospital employee refuse to administer without our consent, I (we) hereby authorize the Director of the Whole Child Program, and/or representatives of Side by Side Studio, Inc. to give consent for us if we cannot be reached by telephone at one of the numbers listed in this application, or because of an emergency, there is not time or opportunity to make a telephone call. In the event that it becomes necessary for one of these persons to give consent for us, we agree to hold such person, as well as Side by Side Studio, Inc., free and harmless and agree to INDEMNIFY such person, as well as Side by Side Studio, Inc., from any claims, demands, or suits for damages (INCLUDING CLAIMS OF NEGLIGENCE) arising from the giving of such consent, as long as the treatment is administered by or under the supervision of a licensed physician.

Parent/Guardian signature: _____

Date: ____ / ____ / ____

WELLNESS POLICY

I understand my child(ren) will not be allowed to attend when he/she is running a fever of 100 degrees or higher, vomiting, has diarrhea, or an unexplained rash. If called due to my child's/children's illness, I will pick up my child(ren) as soon as possible after being contacted. I understand that my child(ren) must be symptom free for 24 hours before returning to school.

Parent/Guardian Signature: _____

Date: ____/____/____

IMMUNIZATIONS

A current KY state immunization certificate must be on file by the first day of attendance. It is required to be updated each time your child receives immunizations. All students must be up to date with vaccinations.

PHOTOGRAPH RELEASE

I hereby grant permission for my child's/children's photographs to be included in Side by Side Studio, Inc.'s email newsletter, local press, video, outreach, social media, and the Studio's website.

Parent/Guardian Signature:

_____ Date:
____/____/____

PARTICIPATION IN SIDE BY SIDE STUDIO WHOLE CHILD PROGRAM I give permission for my child to participate in all activities offered at The Whole Child Nature School and Atelier. These include play time, snack time, and other approved and age appropriate creative movement. The children will play in the front and back yard area as the weather permits.

Parent/Guardian Signature:

_____ Date:
____/____/____

I/We have read, understood and agreed with the policies set forth in the Enrollment Packet and in the Policies and Procedures Parent Handbook. I/We agree to pay all fees with the knowledge that if my/our account becomes delinquent, my/our child(ren) will not be permitted to attend until payment is made in full.

Parent/Guardian Signature:

_____ Date:
____/____/____

Parent/Guardian Signature: _____

Date: ____/____/____