

<p>FOR OFFICE USE ONLY</p> <p>Amount paid: _____</p> <p>Check #: _____</p> <p>Date Received: __/__/__</p> <p>Accompanied Payment for: Fall / Spring</p>
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Parent's Morning Out Enrollment
ALL SAINTS' EPISCOPAL CHURCH
 1425 Cherokee Road, Florence, SC 29505
 (843) 662-7061 www.allsaintsflorence.org
 Monday – Friday 8:00 am to 12:00 pm (Fall/Spring)
 Tuesday – Thursday 9:00 am to 1:00 pm (Summer)
 Leslie Franks – PMO Director lesliefranks@allsaintsflorence.org

First Child's Name: _____ **Birth date:** __/__/__

Second Child's Name: _____ **Birth date:** __/__/__

Third Child's Name: _____ **Birth date:** __/__/__

Mother's Name: _____ **Father's Name** _____

Address: _____ Home Phone: _____
 City: _____ Mom's Work Phone: _____ Mom's Cell: _____
 Zip: _____ Dad's Work Phone: _____ Dad's Cell: _____
 Mother's Place of Business: _____
 Father's Place of Business: _____

Email Address: _____ All Saints' Parishioner: Yes No

Enrollment Fee: \$50.00 per child or \$75 for siblings The Enrollment Fee **is nonrefundable.**

Tuition Rates: \$15.00 per day (Full Week Rate)
\$18.00 per day (Partial Week Rate)
\$20.00 per day (Drop-In Rate)

A late charge of \$15.00 will be due if tuition is paid after the 15th of the month. It is extremely important for payments to be made on time. If you carry an unpaid balance over \$200.00, your child may be dropped and will have to be put back on the wait list to re-enroll.

Days Enrolled: **Full Week** **Partial Week** **Drop-In (CIRCLE ONE)**

If you circled Partial Week, please select your scheduled days:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

You will be charged for these days at the beginning of each month.

In case of sickness call (other than parent)

1st choice: _____ Phone: _____ Cell Phone: _____

2nd choice: _____ Phone: _____ Cell Phone: _____

Doctor's Name: _____ Phone: _____

May Acetaminophen be given? ____ Yes ____ No * If YES what dose? _____

May Ibuprofen be given? ____ Yes ____ No * If YES what dose? _____

Person(s) authorized to pick up child other than parent:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Please list below any health concerns and allergies that your child might have. This is the benefit of your child and to help us better serve the children in our program.

Health Concerns:

1. _____

2. _____

Allergies:

1. _____

2. _____

(If any medication is to be given or kept at PMO for allergic reactions, we need to have a written letter signed by the parent.)

* May we have permission to photograph your child? Yes No

* May we have permission to use your child's photograph in church publications and/or website for the purpose of promotion? Yes No

I have read and agree to abide by all policies/procedures outlined in the Parent's Morning Out handbook and all policies/procedures of All Saints' Episcopal Church.

Signature: _____ **Date:** _____