Shining Stars
CHILDHOOD CARE & EDUCATION CENTRE
P: 943-7077 / 936-7077
Email: shiningstarscayman@gmail.com
www.shiningstarscayman.com
Hours: Monday-Friday (7am-6pm)

Enrollment Application

CHILD'S INFORMATION			
Last Name:	First:	M.I.	D.O.B
Street Address:		Apartment/Unit #:	
Age:	Gender : Boy /Girl	Home Phone:	
Starting Date:	Special Needs or Medical History		
Health Insurance:	Policy Number:	Certificate Number:	
Nationality: ____Caymanian ___Non-Caymanian Specify_____			
Schedule: Drop off Time:	Pick-Up Time:	Part Time: Y/N	Full Time: Y/N
Immunization Record Provided: Y/N	Does your take Medication: Y/N If yes, explain		
Other Illnesses: ( ) Chicken Pox ( ) Measles			
( ) Mumps ( ) Other			

PARENT OR GUARDIAN INFORMATION		
1) Name:	Relationship to child:	
Address:	Employer's Name:	
Phone:	Email:	
2) Name:	Relationship to child:	
Address:	Employer's Names:	
Phone	Email:	

EMERGENCY CONTACT INFORMATION	
Please list two emergency contacts.	
Full Name:	Phone:
Relationship to child:	Email:
Address	
Full Name	Phone:
Relationship to child:	Email
Address	
Name of Doctor:	Phone:

CHILD DEVELOPEMENT

How does your child get along with other children?	( ) Excellent ( ) Good ( ) Fair ( ) Poor ( ) Unsure	Does your child have any fears?	Y / N If yes, explain:_____
Does your child have food dislikes or eating problems?	Y/N If yes, explain:_____	Does your child currently take naps during the day?	Y / N
Does your child have any physical handicap / impairments?	Y/N If yes, explain:_____	Does your child have any allergies?	Y/N If yes, explain:_____

Monthly Rates

RATES :	**Full Time:**	7am-6pm	$650CI (Plan A)	Includes Breakfast, Lunch and snacks
	Part Time:	7am-12:00pm (5 half days or 3 full days)	$495CI	Includes Breakfast, Lunch and snacks

CAMERA ACCESS	$20CI	Closed Circuit Camera Access

Plan of Choice:

The following items are required for your child's enrollment.	1. Completed and Signed Application Form 2. Copy of Immunization Record 3. Copy of Birth Certificate 4. Photo of Child 5. Proof Health Insurance	Notes: **UNIFORMS SETS $30.00 CI**

AGREEMENT AND SIGNATURE - YOU ACKNOWLEDGE AND AGREE BY SIGNING BELOW

1. In the event of an emergency and the emergency contacts listed above are unable to be reached, I authorize the Administrator of Staff to administer emergency treatment on behalf of my child, upon the advice of the attending physician or dentist and transportation to the hospital if deemed necessary.

2. Payments are due in full by the 1st day of each month. A $25CI late payments fee will be assessed for payments made after the due date and a recurring $25CI monthly fee will be assessed until the balance is paid in full. Late pickups are assessed a minimum $25CI fee per late pickup and are due immediately. Furthermore, I agree to pay any and all collection costs associated with this account.

I, the undersigned, believe the above information to be true and correct to the best of my knowledge. I also agree to provide Shining Stars Childhood Care & Education Center with updated information as needed as it relates to my child.

Signature: Date