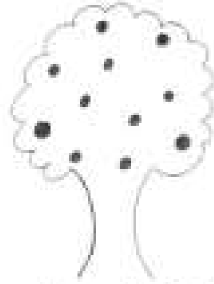
Student's First & Last Name______________________________Date packet is submitted ________

Appletree Academy Enrollment Packet 2024-2025



Thank you so much for choosing Appletree Academy! We have been successfully preparing preschoolers for kindergarten since 1994! Whether you are new to Appletree or a returning family, we greatly appreciate you entrusting us to be a part of your preschooler's educational journey! If you are new to Appletree, please call to set up a tour to start the enrollment process. Next:

1) Please return this completed Packet pages 1-6
2) Submit page 7 to your child's doctor to be completed & signed, then submit it to Appletree
3) The $100.00 supplemental fee (covers the cost of field trips & supplies) & the $50.00 deposit will be automatically deducted from your account. **Both are non-refundable**.
4) Please do NOT send cash, checks, or money orders.

REQUIRED ITEMS:

___Page 1-This summary Form
___Page 2-Appletree Academy Student Information Form
___Page 3-Authorization Agreement Automatic Payments (Ach Debits) Form
___Page 4-Missouri Department of Health and Senior Services Child Care Enrollment Form part 1
___Page 5-Missouri Department of Health and Senior Services Child Care Enrollment Form part 2
___Page 6-Appletree Academy Photo Consent Form
___Page 7-Missouri Dept. of Health and Senior Services Child Medical Exam Form-signed by a Dr.
___Page 8-A copy of your preschoolers CURRENT Immunization Record

___Upon receipt of this packet, you are giving Appletree/Melissa Hertzog (owner) permission to automatically withdraw the $50 deposit and $100 supplemental fee from your account. Both are non-refundable.

WE ONLY ACCEPT HARD COPIES OF EACH FORM. PLEASE DO NOT EMAIL FORMS.

Appletree Academy   Melissa Hertzog, Owner/Director   1800 SW 150 Highway Lee's Summit, MO 64082
(816) 377-6435   appletreeacademy01@gmail.com   www.appletreeacademy.biz
Follow us on Facebook and Instagram

APPLETREE ACADEMY STUDENT INFORMATION TODAY'S DATE:___________

Primary Classes-Age 3 before August 1st & potty trained by the first day of class in September.
Primary Classes attend twice a week, 4 hours each day, and bring a lunch both days
Please check one choice below for a PRIMARY CLASS:
_____PRIMARY MON-WED MORNING HOURS 9:00-1:00 $210 PER MONTH
_____PRIMARY TUE-THU MORNING HOURS 9:00-1:00 $210 PER MONTH

Pre-K Classes- Age 4 before August 1st & potty trained by the first day of class in September.
Pre-K students attend three times a week, 4 hours each day, and bring a lunch all 3 (or 5) days.
Please check one choice below for a PRE-K CLASS:
_____PRE-K MON-WED-FRI MORNING HOURS 9:00-1:00 $265 PER MONTH (3 days)
_____PRE-K TUE-THU-FRI MORNING HOURS 9:00-1:00 $265 PER MONTH (3 days)
_____PRE-K MON-TUE-WED-THU-FRI MORNING HOURS 9:00-1:00 $475 PER MONTH (5 days)

CHILD'S FIRST & LAST NAME________________________________ CIRCLE: BOY/GIRL BIRTHDATE________

HOME ADDRESS_____________________________________CITY____________ZIP CODE_______________

MOTHERS FIRST & LAST NAME___________________________________MOTHER'S CELL______________

FATHERS FIRST & LAST NAME____________________________________FATHER'S CELL_______________

YEAR TO BEGIN KINDERGARTEN ______DISTRICT?_________NAME OF ELEMENTARY SCHOOL?____________

NAMES OF FORMER APPLETREE STUDENTS IN YOUR FAMILY:_____________________________________

NAMES AND BIRTHDATES OF BROTHERS AND SISTERS____

IS THIS A FIRST TIME PRESCHOOL EXPERIENCE FOR THIS CHILD? YES____ NO______

IS SOMEONE OTHER THAN MOM OR DAD PROVIDING TRANSPORTATION ON A REGULAR BASIS?________ NAMES OF ADULTS-***OTHER THAN PARENTS***-DROPPING OFF AND PICKING UP YOUR CHILD:

NAME_____________________________RELATION___________________CELL_________________________

NAME____________________________ RELATION___________________CELL_________________________

THE AGE OF YOUR CHILD BY THIS SEPTEMBER __________YEARS _________MONTHS

DO YOU OR YOUR SPOUSE TEACH SCHOOL NOW OR IN THE PAST? IF SO, WHERE?__________________

FIRST EMAIL ADDRESS____

SECOND EMAIL ADDRESS____

HOW DID YOU HEAR ABOUT APPLETREE?____

AUTHORIZATION AGREEMENT AUTOMATIC PAYMENTS (ACH DEBITS)

I ______________________________________, hereby authorize ***Appletree Academy***, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

____ ________________________________

(Financial Institution Name) (Branch)

____

(Financial Institution Address) (City/State) (Zip)

____ ____________________________________

(Routing Number) (Account Number)

Type of Account: ____ Checking ____ Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

____

(Print Individual Adult Name on the Bank Account)

______________________________________ ____________________________________

(Print Preschoolers First Name) (Print Preschoolers Last Name)

____

(Print First and Last Names of any additional siblings also attending Appletree Academy)

____ _______/________/________

(Signature) (Date)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE

CHILD ENROLLMENT FOR LICENSE-EXEMPT FACILITIES

SAVE
PRINT
RESET

CHILD'S NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

IDENTIFYING INFORMATION

A) MOTHER'S NAME	HOME TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
EMPLOYED BY	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )
B) FATHER'S NAME	HOME TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
EMPLOYED BY	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )

EMERGENCY CONTACT(S) (OTHER THAN PARENT(S) OR DOCTOR)

NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

PERSON(S) AUTHORIZED TO TAKE CHILD FROM THE CHILD CARE FACILITY

NAME	NAME

PLEASE COMPLETE BACK.

TO BE COMPLETED BY CHILD CARE FACILITY

ADMISSION DATE
DISCHARGE DATE
FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.

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CHILD'S NAME

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize

PROVIDER/LICENSEE

to contact the following:

PHYSICIAN OR CLINIC
(Please list name and phone number of physician and/or clinic.)

NAME	TELEPHONE ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL	

PREFERRED HOSPITAL
(Please list name and phone number of hospital.)

NAME	TELEPHONE ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL	

TRANSPORTATION TO AND FROM SCHOOL

I ☐ (DO) ☐ (DO NOT) GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD TO AND FROM SCHOOL.

FIELD TRIPS

I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSIONS AND THAT I WILL BE NOTIFIED WHEN THEY ARE PLANNED.

ACKNOWLEDGEMENTS

A)	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.
B)	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.
C)	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.
D)	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.

PARENT/LEGAL GUARDIAN SIGNATURE ▶	DATE

Appletree Academy Photo Consent Form

We love taking pictures of all our students at Appletree while on field trips and also in the classroom. Our school website and our school Facebook page allow us to share group pictures of all the fun Appletree activities with parents, family, and friends. We will give you a copy of all the pictures we take on the flash drive you provide. We would like your permission please to use some ***group pictures***, which include your child, for advertising our wonderful program at Appletree Academy. We do not post student information on Social Media. I invite you to visit our website at www.AppletreeAcademy.biz to see pictures already posted!! We also welcome parent comments to add to our website. If you would like to add your comments, please email them to **appletreeacademy01@gmail.com**

Please complete the following:

I, the legal parent or guardian of ____,
(print pre-schoolers first and last name)
give my permission for Appletree Academy Preschool to use a group picture which may include my child's photo, on their website, Facebook page, & newspapers.

I understand that my child's name or other personal information about my child will ***not*** be posted on Social Media.

Parent or legal guardian name:

________________________________ ________________________________
(parent signature) (parent name **printed)**

Date______________

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

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.)

____
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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

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.