



# The Matthew Reardon EARLY LEARNING ACADEMY *for the love of children*

## 2019-2020 ENROLLMENT APPLICATION

Please submit this completed enrollment packet, along with a \$100 registration fee, either by mail or in person. Checks should be made payable to The Early Learning Academy.

Mailing address: P.O. Box 14669, Savannah, GA 31416

Physical address: 11500 Middleground Road, Savannah, GA 31419

If you have questions, please email [eladirector@matthewreardon.org](mailto:eladirector@matthewreardon.org).

### **Ages Served and Tuition Fees**

- *Ages:* Toddlers: 18-24 months; Early Preschool: 24-36 months; Preschool: 36 months – 48 months; Pre-K4: 48 months – 60 months
  - *Times:* Academic Program 8:30 a.m. to 2:30 p.m.,  
Extended care (7:30 a.m. – 6:00 p.m.) year-round. All children not enrolled in our Extended Care Program should arrive between 8:15 a.m. and 8:30 a.m. and depart between 2:30 p.m. and 2:45 p.m.
  - *Academic Tuition:* Paid monthly and due on the 1<sup>st</sup> of each month \*\*
    - *Toilet Trained:* \$629 per month
    - *Diapered:* \$672 per month
    - Extended Care Hours: Additional \$50 per week per child
- \*\* There is no reduction in fees because of student absences or holidays.  
20-day notice of withdrawal is required.

\*\*\*Children with autism may pay additional fees for early intervention therapies, which may be insurance reimbursable.



**2019-2020  
ENROLLMENT FORM**

**Entrance Date** Child's \_\_\_\_\_ **Withdrawal Date** \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone Number \_\_\_\_\_ Preferred email: \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Father's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's email: \_\_\_\_\_ Mother's email: \_\_\_\_\_

Child's Living Arrangements: (check one)  Both Parents  Mother  Father  Other

Child's Legal Guardian(s): (check one)  Both Parents  Mother  Father  Other

The child may be released to the person(s) signing this agreement and to the following:

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name of School child currently attends, if any: \_\_\_\_\_

Child's doctor or clinic name \_\_\_\_\_

Doctor/clinic phone # \_\_\_\_\_

My child has the following special needs: \_\_\_\_\_

\_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: \_\_\_\_\_

\_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_

suffer an injury or illness while in the care of the Matthew Reardon Early Learning Academy (MRELA) and MRELA is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

**Parent/Guardian:** \_\_\_\_\_

Signature

**Date:** \_\_\_\_\_

**MRELA Director:** \_\_\_\_\_

Signature

**Date:** \_\_\_\_\_

