

PLAYFUL WONDERS **FUN WITH TWOS AND THREES**

Mail Completed Applications:
977 Main Street New Rochelle, New York 10801
914-738-6518 • www.juniorwonders.com

June 28, 2010 - July 29, 2010

Name _____ DOB _____

Address _____

Home Phone _____ Cell _____

E-Mail _____

Current School _____

Local Emergency Contact _____

Phone _____

Fees:	20 Sessions - 9:00am - 12:00pm	\$575.00
	15 Sessions - 9:00am - 12:00pm	\$485.00
	10 Sessions - 9:00am - 12:00pm	\$350.00

We Require a \$50.00 Deposit With This Application
Please make checks payable to: Playful Wonders, Inc.
Full Payment is due by Friday, June 4, 2010

A Medical Exam and Immunization Record is required if your child does not currently attend Junior Wonders.

TUITION AGREEMENT

The undersigned hereby enrolls my child _____
into the Fun With Twos and Threes Program at Playful Wonders.
**I am fully aware that there will be no refunds given after this
application is handed in and accepted.**

My child will attend _____ days per week from 9:00am to 12:00pm on
the following days:

Monday ___ Tuesday ___ Wed. ___ Thursday ___

I understand that the Program will begin on Monday, June 28th and
will end of Thursday, July 29th. I further understand that full payment
is due by Friday, June 4, 2010.

Signature/Date

**There will be a 10% discount if all fees are paid in full by
Friday, April 16, 2010**

Receipt of Payment

Parent's Name _____ Date _____

Child's Name _____ Amt. Received _____

Child's Schedule _____

Balance due _____

****Full payment due by 6/4/10**

Signature

**Summer Program Site: Christ the Redeemer Church
1415 Pelhamdale Avenue
(across from the N.Y.A.C. Club)
Pelham Manor, New York 10803**

Playful Wonders Summer Program
Emergency Medical Treatment Form

I hereby give Isabelle Lombardi, Director of Playful Wonders, or her designee, permission to obtain emergency medical care for my child _____ in the event that I or my spouse cannot be reached.

The following information may be necessary in obtaining emergency care:

Insurance Carrier _____

Policy # _____

Name of Policy Holder _____

Primary Care Physician _____

Physician's Address _____

Physician's Phone _____

I hereby give permission for my child _____ to be transported to the nearest hospital and treated in case of a severe emergency.

Does your child have any food allergies? _____

Does your child receive special services? _____

Does your child take any regular medications? _____

If so, give name, dosage and frequency _____

Does your child require administration of any medication during our program hours?

Parent Signature _____

Date _____

Playful Wonders Summer Program

Authorized Release Form

My child _____ may be released to the following people in the event that I cannot be there. (Note: Spouses must be listed, if authorized)

Name _____

Relationship _____

Phone # _____

Name _____

Relationship _____

Phone # _____

Name _____

Relationship _____

Phone # _____

I understand that my child can be released to the above mentioned people only. If there are any changes or amendments, I understand that it must be submitted in writing, otherwise, my child will not be released.

Parent Signature _____

Date _____