



## MAPLE SEEDS PRESCHOOL COOPERATIVE (MSPC)

3030 Kessler Blvd East Drive · Indianapolis, IN 46220 · 317-767-3003

<http://www.mspcindy.com>

### 2019-2020 Parent Agreement

Maple Seeds Preschool Cooperative (MSPC) depends on the willing participation of each parent to ensure proper operation. It is important that parents understand and agree to accept the responsibilities involved. As MSPC parents, we agree to the following:

- To read and comply with the By-Laws of Maple Seeds Preschool Cooperative.
- To complete and return the health forms of the child and participating adults, as required by the Indiana State Board of Health.
- To submit documentation of cleared background check
- To provide the co-op with accurate and current emergency information.
- To complete the Classroom Participation Training (new families only) sponsored by the Indianapolis Council of Preschool Cooperatives and pay the cost of the program.
- To participate in the classroom on assigned co-oping days, to arrive on time, to bring a snack as designated, and to find a substitute if unable to participate.
- To support the co-op financially by paying tuition by the first day of each month. Tuition is late on the 10<sup>th</sup> of the month, and if prior arrangements have not been made with the treasurer, a \$10 late fee will be assessed.
- To participate in co-op fundraising projects.
- To volunteer for and complete job assignments on the job list prepared by the Deep Cleaning Coordinator.
- To attend 3 Parent Education programs as required by ICPC.
- To attend parent-teacher conferences.
- To hold a job within the school.

I/We, the parent(s) of \_\_\_\_\_, wish to enroll my/our child in the Maple Seeds Preschool Cooperative. I/We have read the above information and agree to the terms set forth.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

# MSPC Parent Contact Form

Attach/insert photo of child here

This form will be filed for each child in an Emergency Binder in the classroom.

Child's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Child's special needs, chronic medical condition and/or long-term medications: \_\_\_\_\_

**Parent/guardian 1 name:** \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Parent/guardian 2 name:** \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other adult(s) authorized to pick up child from MSPC: \_\_\_\_\_

Emergency Contact 1: \_\_\_\_\_  
Name Relationship Phone

Emergency Contact 2: \_\_\_\_\_  
Name Relationship Phone

Emergency Contact 3: \_\_\_\_\_  
Name Relationship Phone

*Parents are always the first call - additional contacts used in the event you are unreachable.*



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### *Consent for Medical Treatment*

In the event that reasonable attempts to contact me or the emergency contacts at the phone numbers I have provided to Maple Seeds Preschool Cooperative have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the doctor, hospital, or dentist listed in the MSPC Parent Contact Form *or*, in the event that the designated preferred practitioner is **not** available, by another licensed physician or any other hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

In the event your child begins to display illness while at school, your child may be supervised in a separate location out of the classroom for their own comfort and for the wellbeing of other students while awaiting pickup.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

### **REFUSAL OF CONSENT FOR MEDICAL TREATMENT**

I do not give consent for medical treatment for my child. In the event of illness or injury requiring emergency medical treatment, I wish Maple Seeds Preschool Cooperative to not take action OR to (specify):

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Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_



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### *Family Background*

PARENTS/GUARDIANS: Which of the following best represents the racial or ethnic heritage of the *parents* or *guardians* in your household? Choose all that apply.

- Non-Hispanic White or Euro-American
- Black, Afro-Caribbean, or African American
- Latino or Hispanic American
- East Asian or Asian American
- South Asian or Indian American
- Middle Eastern or Arab American
- Native American or Alaskan Native
- Other
- Prefer not to answer

ENROLLED CHILD: Which of the following best represents the racial or ethnic heritage of the *child* you are enrolling? Choose all that apply.

- Non-Hispanic White or Euro-American
- Black, Afro-Caribbean, or African American
- Latino or Hispanic American
- East Asian or Asian American
- South Asian or Indian American
- Middle Eastern or Arab American
- Native American or Alaskan Native
- Other
- Prefer not to answer



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### *ICPC Child Protection & Weapons Policy*

#### INDIANA COUNCIL OF PRESCHOOL COOPERATIVES CHILD PROTECTION AND WEAPONS POLICY ACKNOWLEDGEMENT

I, \_\_\_\_\_(print name) have read the ICPC Child Protection & Weapons Policy and agree to abide by the rules and procedures stated therein.

Anyone who violates this policy may be subject to disciplinary actions at the discretion of the executive board.

Name of school \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_



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### *Photo Release*

#### **PERMISSION FOR PHOTO/VIDEO RELEASE:**

During the school year, we may videotape and take still pictures of the children and their work. The school reserves the right to use these photos and videos for news release, the school's website, the yearbook, school-related video and slide presentations, marketing purposes, etc. (Please complete below for all children attending MSPC.)

Student \_\_\_\_\_ Class \_\_\_\_\_

Student \_\_\_\_\_ Class \_\_\_\_\_

\_\_\_\_\_ Yes, I grant permission for MSPC to use my child(ren)'s photo for the publications listed above.

\_\_\_\_\_ No, please do not use my child(ren)'s photo.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_