Child Enrollment Form

Entrance Date: _____ **Withdrawal Date:** _____

Child's Program (check all that apply):

[ ] Full Time ['] Before School [ ] After School [ ] Summer Camp [ ] Drop In

Child's Name:

_____

(Last) (First) (Middle) (Preferred)

Date of Birth: _____ **Sex:** _____ **Age:** _____

Child's Address:

_____

(Street) (Apartment #)

_____

(City) (State) (Zip)

Name of Medical Clinic: _____
Name of Physician: _____
Telephone Number: _____

My child has the following pre-existing illness, allergies, or health concerns:

_____

My child has the following special need(s):

_____

Child's Living Arrangements (check one):
[ ] Both Parents [ ] Mother [ ] Father [ ] Other: _____
Child's Legal Guardian (check one):
[ ] Both Parents [ ] Mother [ ] Father [ ] Other: _____

Father's Name:

_____

(Last) (First) (Middle) (Preferred)

Father's Address:

_____

(Street) (Apartment #)

_____

(City) (State) (Zip)

Father's Telephone Numbers:

Home: _____ Cell: _____ Work: _____

Father's E-Mail:

_____

Father's Place of Employment: _____

Work Address:

_____

(Street) (Apartment #)

_____

(City) (State) (Zip)

Mother's Name:

_____

(Last) (First) (Middle) (Preferred)

Mother's Address:

_____

(Street) (Apartment #)

_____

(City) (State) (Zip)

Mother's Telephone Numbers:

Home: _____ Cell: _____ Work: _____

Mother's E-Mail:

_____

Mother's Place of Employment: _____

Work Address:

_____

(Street) (Apartment #)

_____

(City) (State) (Zip)

Emergency Contacts / Authorized Pick-ups:

Name Address (Street, City, State, Zip) Phone Number

1._____

Relationship to child:_____

2._____

Relationship to child:_____

3._____

Relationship to child:_____

4._____

Relationship to child:_____

5._____

Relationship to child:_____

How did you hear about us?: _____

_____ _____

Signature (Parent/Guardian) Date

EMERGENCY MEDICAL AUTHORIZATION

Should _____, _____
(Name of child) (Date of Birth)

suffer an injury or illness while in the care of Start Smart Learning Center, Inc. and the facility is unable to contact me immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of health care is:

_____
Physician/Clinic Name Telephone Number

Known medical conditions (i.e. diabetic, asthmatic, drug allergies):

_____

_____

_____

_____ Date_____
Signature of Parent/Guardian

_____
Telephone Number

PARENTAL AGREEMENT WITH START SMART LEARNING CENTER

1. Start Smart Learning Center, Inc. agrees to provide day care for _____
(Name of Child)
_____ on Monday through Friday, 6:00 a.m. to 6:00 p.m. My

child will participate in the following meal plan:

Breakfast
Lunch
Afternoon Snack

Or if my child is under 1 year of age an Infant Feeding Plan will be on file and updated at any time the infant's feeding plan is changed.

2. Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of child, name of medication, prescription number (if any), dosage, date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

3. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), or person authorized by parent(s).

4. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g. telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

5. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable diseases, which include my child.

6. Start Smart Learning Center, Inc. agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

7. I have provided Start Smart Learning Center, Inc. with an immunization form 3231 showing all current immunizations have been administered and when any additional immunizations are due.

8. I understand that if my child becomes ill during the course of the day with a fever of 101 or above, vomiting, or chronic diarrhea, my child will not be allowed to return to

the center before twenty-four (24) hours from when the fever breaks or the last time vomiting or diarrhea occurs.

9. I understand Start Smart Learning Center, Inc. is mandated by Georgia law to report any suspected child abuse or neglect to the proper authorities.

10. I will bring a minimum of one change of seasonally appropriate clothes to be kept in my child's cubby at all times.

11. I agree that the Parent and Student Handbook is incorporated herein and made a part hereof.

12. I have received a copy and agree to abide by the policies and procedures for Start Smart Learning Center, Inc.

_____ Date _____
Signature of Parent/Guardian

_____ Date _____
Signature of Parent/Guardian

_____ Date _____
Signature of Facility Administrator/Person in Charge

PERMISSION TO PHOTOGRAPH AND FILM

I give START SMART LEARNING CENTER, INC. permission to photograph, film, videotape, and/or audio record my child. I understand that said visual or audio recordings may be used by television stations, radio stations, print media, and/or Start Smart Learning Center, Inc. itself in any of the various publications, displays, and/or exhibits.

_____
Child's Name

_____
Signature of Parent/Guardian

_____
Date

Authorization to Dispense External Preparations

590-1-1-.20(l)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file