Kids Come First Early Learning Centers
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ENROLLMENT FORM

Entrance Date (mm/dd/yyyy) Withdrawal Date (mm/dd/yyyy) Birth date (mm/dd/yyyy)

Child's Name (last, first, middle initial) Child's Nickname Gender Age

Home Address (Street Address, City, State and Zip Code)

( )
Home Telephone Number Child's Primary Language

School Attending (for pre-school and school age children only)

Mother's E-mail Address Father's E-mail Address

Mother's Name Home Address (If different) ( ) Mother's Cell Number

Mother's Employer Street, City, State and Zip ( ) Business Number

Father's Name Home Address (If different) ( ) Father's Cell Number

Father's Employer Street, City, State and Zip ( ) Business Number

Regular Care Arrangements: Lives with [ ] Both Parents [ ] Mother [ ] Father [ ] Other: _____

Are there any custody arrangements for your child? _____

If yes, please describe: _____
(A court order with supporting documentation describing custody arrangements and restrictions must be provided.)

Child's Legal Guardian(s) [ ] Both Parents [ ] Mother [ ] Father [ ] Other _____

Pick up/Drop off Authorizations: Bright from the Start requires a minimum of one person other than a parent and/or guardian. My child may be released to the person(s) signing this agreement or to the following:

Name	Address (include complete street address, city, state and zip code)	Telephone

Emergency Contacts: Persons to contact in case of an emergency when parents cannot be reached. These people are authorized to make medical decisions concerning my child. Bright from the Start requires a minimum of one person other than a parent and/or guardian.

Name	Address (include complete street address, city, state and zip code)	Telephone

_____(_____)_____
Pediatrician or child's primary health care source name Telephone number

_____(_____)_____
Dentist name Telephone number

Does your child have any allergies or food restrictions?_____ If yes, please describe and attach care plan: _____

_____

Does your child have any diagnosed special needs or medical conditions? _____ If yes, please describe: _____

_____

Are your child's activities restricted by any special needs, medical or other conditions? _____ If yes, please describe: _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at this center. (circle one) **NONE YES (see below)**

_____

_____

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 unmentioned above: (circle one) **NONE YES (see below)**

_____

_____

Other Helpful Information:

_____

_____

Sleeping Schedule: _____
(for children under 36 months only)

Toilet Schedule: _____
(for children under 36 months only)

Siblings: _____
(Please list names and ages)

Medical Insurance Information

Insurance Carrier _____ Insured's Name _____

Primary Care Physician Name _____ Telephone (_____)_____

ID or Policy # _____Member Service Number (_____)_____

EMERGENCY MEDICAL AUTHORIZATION

Should_____
(Child's Name) (Date of Birth)

suffer an injury or illness while in the care of Kids Come First ELC and the facility 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 agree to keep the facility informed of changes in telephone numbers, etc. where I/We can be reached. The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child. Permission is granted to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical and transportation expenses incurred.

_____(_____)_____
Signature of Parent/Guardian (on behalf of both parents/guardians) Date (mm/dd/yyyy) Telephone

INFANT FEEDING AND CARE PLAN

591-1-1-.15 (2) **Feeding of Children Under One (1) Year of Age**

- A signed written feeding plan for children under one (1) year of age shall be obtained from parents.
- Instructions from the parent shall be updated regularly as new foods are added or other dietary changes are made.
- The feeding plan shall be posted in the child's assigned room

Child's Name _____ Date _____

Birthdate_____

Does the child take a bottle?		Yes [ ]	No [ ]
Is the bottle warmed?		Yes [ ]	No [ ]
Does the child hold own bottle?		Yes [ ]	No [ ]
Can the child feed self?		Yes [ ]	No [ ]
Does the child eat:			
Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used? _____
Amount of formula to be given? _____
Updated amounts of formula? _____ Date _____
_____ Date _____
_____ Date _____
Does the child take a pacifier? Yes [ ] No [ ]
When? _____
Food likes _____ Food dislike_____
Food Allergies- including any premixed formula _____

Child's Schedule

Breakfast _____ _____
Approximate Time Types and approximate amount of food

Lunch _____ _____
Approximate Time Types and approximate amount of food

Dinner _____ _____
Approximate Time Types and approximate amount of food

Morning Nap _____ Afternoon Nap _____
Approximate Time Approximate Time

Instructions for the introduction of solid foods _____

_____

As needed, please list updated instructions regarding adding new foods or other dietary changes. _____

_____

Has your child had any feeding problems? (Please describe in detail)

_____

_____

Is your child: ☐ breast fed ☐ bottle fed ☐ weaned

INFANT FEEDING AND CARE PLAN (cont.)

Supplemental infant information:

Describe your child's present napping pattern _____

_____

Does your child usually cry when going to sleep? ☐ No ☐ Yes
Does your child cry when waking? ☐ No ☐ Yes
Do you have any special ways of helping your child go to sleep?_____

_____

Does your child have any special needs?_____

_____

_____

_____

Does your child have any allergies? ☐ No ☐ Yes Describe: _____

Has your child had a serious illness? ☐ No ☐ Yes Describe: _____

_____

Has your child had any surgical procedures? ☐ No ☐ Yes Describe: _____

_____

Does your child take any medications on a regular basis? (Please give details)_____

_____

_____

Please indicate which of the following diseases your child has previously experienced:

☐ Whooping Cough	☐ Pneumonia	☐ Mumps
☐ Chicken Pox	☐ Measles (10 day)	☐ Allergies
☐ Eczema	☐ High Temperature (Over 103)	☐ Neurological
☐ Roseola (24 Hr. Measles)	☐ Rubella (3 day-German Measles)	☐ Recurrent Ear Infections

☐ Other _____

Please take a moment to tell us any thing else that would help us to provide the best care for your child.

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature _____ Date _____

Bright from the Start
Georgia Department of Early Care and Learning

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____
(Not to exceed two weeks without a physician's statement)

_____ _____
PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc…)

	DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	ADMINISTERED BY
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication

Authorization to Dispense External Preparations

590-1-1-.20(1)

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

Transportation Agreement

This is to certify that I give _____
Name of Facility

Permission to transport my child _____
Name of Child

from _____ at _____ (am/pm)
Pickup Location

to _____ at _____(am/pm).
Delivery Location

My child will be transported from _____at _____(am/pm)

to _____ at _____(am/pm)
Delivery Location

on the following days:

_____ Monday
_____ Tuesday
_____ Wednesday
_____ Thursday
_____ Friday

_____ is authorized to receive my child. In the event the authorized
Name of Authorized Person

If person is not present to receive my child, the following procedures are to be followed:

_____

_____

_____

The _____is approximately _____ miles from the center.
Location
In the event that my child is not to be transported as outlined above, I agree to notify the

_____.
Facility

Signature (Parent/Guardian) _____ Date _____

DO NOT LEAVE ANY SPACES BLANK

FIELD TRIP PERMISSION FORM

Dear Parents,

On _____, we will be going on a field trip to
Date

_____, _____.
Name Address

We will leave the center at _____ and will return at _____.

If your child can be included, please sign below indicating your permission.

_____
Signature (Parent/Guardian)

_____
Date

Parents or Guardian's
Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, _____, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____

Parents or Guardian's Signatures **Date**

_____ _____

Parent or Guardian (Print Names) **Date**

_____ _____

Center Director's Signature **Date**

Permission to Photograph

I,_____
(Parent or Guardian's name)

Give permission for Kids Come First Early Learning Centers
(Name of childcare provider or facility)

To photograph my child,_____
(Child's name)

For the following purposes:

Type of Use:	**(Check all that apply)**	
	Grant Permission	**Decline Permission**
Still Photographs:		
Display on daycare bulletin boards, show to current and prospective clients		
Display in facility's scrapbook		
Display still photos on facility's website*		
Use still photos in promotional materials		
Videos:		
Show to current and prospective clients		
Display video on facility's website*		
Use videos in promotional materials		

* Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:_____
(Parent or Guardian signature and date)

PARENTAL AGREEMENT WITH KIDS COME FIRST ELC, INC.

1. Kids Come First Early Learning Centers agree to provide child care for _____
Name child is called

on _____, _____a.m. to _____p.m.
days of week

from _____ to _____. My child will participate in the following meal plan:
Month Month

(Circle 3 meals/snacks)

Breakfast Morning Snack Lunch Afternoon Snack Evening Meal Bedtime Snack

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); person authorized by parent(s); or facility personnel.

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. Kids Come First ELC agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable diseases, which include my child.

6. Kids Come First ELC 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 received, reviewed and understand the Parent Handbook and related information concerning the Center and the services provided by Kids Come First ELC. I will use the program in accordance with the terms of the Parent Handbook and Kids Come First ELC policies and procedures made available at the Center. Use of the Center and the child care services may be denied in the event I do not comply with the terms of this Agreement, or when determined by Kids Come First ELC to be in the best interests of my child or the children using the Center. The availability of the Center and the child care services are subject to change at any time.

8. **The parties agree that:** _____ (parent(s)/guardian(s) name)releases Kids Come First ELC and its officers, employees or agents from all liability which may arise as a result of Kids Come First ELC administering asthma treatment or following the directions in the Authorization (including any additional physician's instructions or clarifications) as long as such employees or agents exercise reasonable care in taking such actions. _____(parent(s)/guardian(s) name) also releases Kids Come First ELC and its officers, employees or agents from all liability arising out of the use of any materials and/or equipment supplied by the parent(s)/guardian(s) in connection with the asthma treatment as long as such employees or agents exercise reasonable care in the use of such materials or equipment.

Signature (Parent/Guardian) _____ Date _____

Signature (Facility Director) _____ Date _____