Child Enrollment Form

_____
Entrance Date

_____
Child's Name Sex Age Birth date

_____
Home Address

_____
Parent #1 Name Home Address (If different from child) Phone Number

_____
Place of Employment/Address of Employment/Business Phone Number

_____
Parent #2 Name Home Address (If different from child's)/Phone Number

_____
Place of Employment/Address of Employment/Business Phone Number

Parent #1 Email - _____

Parent #2 Email - _____

Child's Living Arrangements: ( ) Both Parents ( ) Parent #1 ( ) Parent #2 ( ) Other

Child's Legal Guardian(s): ( ) Both Parents ( ) Parent #1 ( ) Parent #2 ( ) Other

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

Name	Relationship To Child	Address (include phone #, complete address, city, state, and zip code)

Persons to contact in case of an emergency when parents cannot be reached:

Name Phone Number

_____

_____

Name of public or private school child attends, if any:

_____

Physician/Clinic's Phone Number:

_____

My child has the following special need(s) [Circle one, Describe below]: YES NO

_____

The following special accommodation(s) may be required to most effectively meet my child's need's while at this center (include religious preferences) [Circle one, Describe below]: YES NO

_____

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 [Circle one, Describe below]: YES NO

_____

If your child is an infant, please indicate any habits he/she has:

_____

Where did you hear about Kids' Zone Daycare and Learning Center?

Signed: _____ **Date:** _____
(Parent/Guardian)

Signed: _____ **Date:** _____
(Facility Administrator/Person-In-Charge)

Thank you for your confidence in
Kids' Zone Daycare and Learning Center.

Where learning and nurturing go hand in hand.

Please visit us on social media –
www.kidszonelearningcenter.com
www.facebook.com/KidsZoneECobb

Food Allergy Action Plan

Child's Name: _____ D.O.B: _____Teacher: _____

ALLERGY TO: _____

Asthmatic Yes*□ No □ *Higher risk for severe reaction

♦ STEP 1: TREATMENT ♦

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*:		□ Epinephrine	□Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine	□Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	□ Epinephrine	□Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□Antihistamine
•Throat†	Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□Antihistamine
• Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□Antihistamine
• Other†	_____	□ Epinephrine	□Antihistamine
• If reaction is progressing (several of the above areas affected), give		□ Epinephrine	□Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® or EpiPen® Jr. (see next page for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Call Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

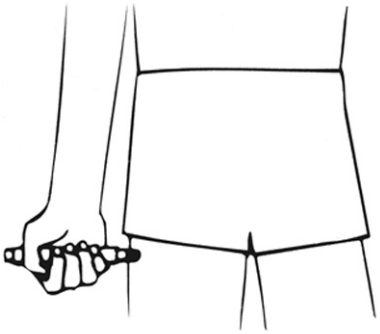
Doctor's Signature_____ Date_____

Food Allergy Action Plan (cont.)

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Once EpiPen® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

** *Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Medical Care and Emergency Contact Information

Child's Name: _____ Birth Date: _____

Address: _____

Parent #1 Name: _____ Phone (H) _____ Phone (W) _____

Parent #2 Name: _____ Phone (H) _____ Phone (W) _____

Alternate Emergency Contact 1): _____ Phone _____

Alternate Emergency Contact 2): _____ Phone _____

Child's Physician: _____ Phone _____

Family Physician: _____ Phone _____

Known allergies of child (medicine, food, environmental etc.): _____

_____

Describe past serious illnesses or hospitalization, with dates: _____

_____

Medicine taken by child: _____

Date of last tetanus injection: _____

Describe all physical conditions or illnesses, which could affect the child's participation in the programs or proper medical treatment (diabetes, epilepsy, poor blood clotting, etc.): _____

_____

Health Insurance: Company _____ Policy # _____

Emergency Medical Treatment Consent

I hereby give Kids' Zone Daycare and Learning Center permission to provide first aid care for my child,

_____. In the event I cannot be reached, I hereby authorize Kids' Zone Daycare and Learning Center to transport my child to the emergency room of the hospital(s), and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). If I have not specified any hospital(s) below, my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred. Nearest Hospital – Children's Hospital of Atlanta.

_____ _____

Parent/Guardian **Date** **Parent/Guardian** **Date**

Authorization to Dispense
External Preparations

590-1-1-.20(1) 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 Kids' Zone Daycare and Learning Center permission to apply one or more of the following topical

preparations to my child _____ (child's name), 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**

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Parent #1 Name _____

Home/Cell Phone _____ Work Phone _____

Parent #2 Name _____

Home/Cell Phone _____ Work Phone _____

Person to notify in an emergency and if parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Kids' Zone Daycare & Learning Center cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness _____ Date_____

General Release

I verify the above information to be correct and true. I hereby grant permission for the information provided in this Registration Form to be distributed to certain providers in connection with preschool activities, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by the providers in connection with preschool activities or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

Child's Name: _____

Signature (Parent/Guardian): _____

DATE: _____

Photograph/Videotape Release

I hereby grant permission for Kids' Zone, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Kids' Zone or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, by photograph and/or videotape in connection with daily activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site. The undersigned hereby jointly and severally releases, acquits, forgives, and discharges Kids' Zone, DECAL, and other entities contracted by Kids' Zone or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child. This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

Child's Name: _____

Signature (Parent/Guardian): _____

DATE: _____

Parental Agreement

1. Kids' Zone Daycare and Learning Center (Kids' Zone) agrees to provide care for _____

   on _____ (days of the week) from _____ am to _____ pm

   from _____ (month) to _____ (month).

2. My child will participate in the following meal plan (circle applicable meals and snacks):

   Breakfast Lunch Afternoon Snack

3. 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.

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

5. 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.

6. Kids' Zone agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, and exposure to communicable diseases, which include my child.

7. Kids' Zone 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.

8. I understand my weekly tuition rate is $_____ per week payable on Monday of the week of services. Childcare fees are due regardless of attendance. A non-refundable enrollment fee of $_____ is due upon enrollment of my child. A non-refundable supply fee of $_____ will be billed on your yearly anniversary date.

9. I agree to provide Kids' Zone with a 2-week notice prior to any vacation time and agree to pay child care fees to hold my child's position during any vacation time or extended leave due to illness. Full payment must be received whether or not my child attends. (See Parent Handbook for exceptions).

10. Parent and Kids' Zone agree to provide a 2-week written notice to terminate this contract, during which time fees will be due and payable to Kids' Zone. If a 2-week written notice is not given to Kids' Zone prior to withdrawal of my child then the final 2-week fees will still be payable to Kids' Zone.

11. I have received a copy of the Parent Handbook and agree to abide by the policies and procedures of Kids' Zone.

12. I have provided, or will provide, my child's updated immunization records to Kids' Zone within one week of my child being enrolled.

Signature (Parent or Guardian) _____ **Date** _____

Signature (Kids' Zone) _____ **Date** _____

Parent Permission
Ages & Stages Questionnaire

Our staff's goal is to develop the total child, socially, cognitively, and physically through guided hands on exploration as well as individual imagination. Each day provides a new chance for us to engage and excite your child's imagination and help develop a love for learning.

Throughout the early years, your child will grow and change tremendously. In order to track your child's social, cognitive, and physical growth, Kids' Zone Daycare and Learning Center uses ASQ "Ages & Stages Questionnaire" and other developmental assessment tools "Assessment Tools." The Assessment Tools help staff at Kids' Zone Daycare and Learning Center to detect early signs of developmental delays and concerns.

For the first year, starting at 2 months, children will be assessed every two months using the ASQ. After that time, children will be assessed based on an annual schedule using age appropriate Assessment Tools.

I give Kids' Zone Daycare & Learning Center permission to use the Assessment Tools when necessary for my child,

_____

Please Print Child's Name

_____ _____

Parent's Signature **Date**

Funds Transfer Authorization Form

I (we) hereby authorize Kids' Zone Daycare and Learning Center to initiate debit entries to my (our) checking or savings account, indicated below **(Section A),** OR initiate credit card charges to the below referenced credit card account **(Section B)**. To properly affect the cancellation of this agreement, I (we) are required to give 10 days' written notice. Credit union members: Please contact your credit union to verify account and routing numbers for automatic payments. Please check with us for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Bank Account)

Name _____ Phone # _____

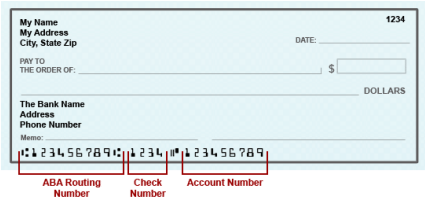
Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Number _____ Account Number _____ ( )Checking ( )Savings

Authorized Signature _____



SECTION B (Credit and Debit Card – 3.99% fee applies)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Authorized Signature _____