

CHILDREN'S ENROLLMENT FORM

Entrance Date _____ Withdrawal Date _____

Child's Name _____ Sex _____ Age _____ Date of birth _____

Home Address (Street) _____

City _____ State _____ Zip _____

Home Phone Number _____

Father's Name _____ Home Phone Number _____

Father's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Father's Place of
Employment _____ WorkPhone _____

Employee's Street
Address _____ City _____ State _____ Zip _____

Mother's Name _____ Home Phone Number _____

Mother's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Mother's Place of
Employment _____ WorkPhone _____

Employee's Street
Address _____ City _____ State _____ Zip _____

Child's Living Arrangements: (check one) Both Parents Mother Father Other

Child's Legal Guardian(s): (check one) Both Parents Mother Father Other

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name _____

Doctor/clinic phone #: _____

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

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: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth _____ suffer an injury or illness while in the care of (Facility name) _____ 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) shall assume responsibility for payment for services.

Parent/Guardian: _____ Signature _____

Date: _____

Facility Administrator/Person-In-Charge: _____ Signature _____

Date: _____

Parental Agreements with Child Care Facility

The _____ agrees to provide child care for
(Name of Facility)
on _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
(Month) (Month)

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

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

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; dosages; 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.

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.

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.

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

The _____ 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.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for
_____.
(Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

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

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

*Name Address

(Street-City-State-Zip)

Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

*Name _____ Address _____

(Street-City-State-Zip)

Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

About Your Child

Child's Full Name: _____ Nickname: _____

Siblings (Name & Age): _____

Has your child been in daycare before? If yes, name of provider or center:

Dates care was provided, from _____ to _____

Reason care was terminated: _____

General:

What is your child's general mood: _____

Favorite Activities: _____

Fears (If any): _____

Eating Habits:

Does your child have a special diet or are there any foods that should not be served to your child?

Your child's favorite foods: _____

Least favorite foods: _____

Does your child eat independently? YES _____ NO _____

Infants only:

_____ Formula _____ Breast Milk _____ Solid Food _____ Baby Food

Feeding Schedule:

Sleeping Habits:

Does your child have a regular bedtime schedule? YES _____ NO _____

What time does your child usually wake up in the morning? _____

What time does your child usually go to bed at night? _____

Does your child take naps and for how long? _____

Does your child generally sleep through the night? YES _____ NO _____

Health Concerns:

Does your child have any known health concerns? If yes, please describe:

Is there any hearing or vision problems? If yes please describe:

Does your child have any known allergies? If yes, please list allergy and how it is dealt with:

Does your child suffer from any of the following on a regular basis (check all that apply)?

_____ Nosebleeds, _____ Headaches, _____ Sore Throats, _____ Stomachaches
_____ Seasonal Allergies, _____ Ear Infections, or Other: _____

Potty:

Is your child potty trained: _____

When we go potty, we call #1: _____ and #2: _____

Anything else about your child you feel I should know?

Tuition & Fees Policy

Hours of Operation: 5:30am-7:00pm Monday-Friday

- Full tuition is due on Mondays, regardless if your child attends that Monday or not. Sickness does excuse making your payment on Monday.
- Weekly tuition is due on Monday by 7pm for the upcoming week in advance.
- If the tuition is not paid on Monday by 7pm a fee of ~~\$25~~ \$30 will be applied each day tuition is not paid.
- If late tuition is not paid by Monday at 7pm, your child will not be allowed to return until your account is paid in full.
- A two-week written notice is required for enrollment changes and or disenrollment.
- For the love of kids may experience an annual increase.
- If you are late picking up your child, there will be a late pick-up fee of \$5 every minute past your pickup time.

Parent Signature:

Date:

PERMISSION TO PHOTOGRAPH

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Dear Parents and Guardians,

At **For the love of kids**, we use our website and Instagram page to keep parents of children attending our daycare updated online. We also use this as a means to help illustrate our services and curriculum to parents hoping to choose For the love of kids for their child.

We publish photographs and/or videos taken at the daycare on our website and Instagram page. Please fill out the below form so we understand your decision regarding your child. Please note that at no stage will a child's private details or name appears alongside their picture.

Please check the appropriate box below:

I do give permission for my child _____'s picture to be used by **For the love of kids**.

I do not give permission for my child _____'s picture to be used by **For the love of kids**.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

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Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

Center Name: For the Love of Kids

PART I: Child(ren) or Adult enrolled to receive day care		Child(ren) in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in Part II)								
Name: (Last, First and Middle Initial)		SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers. Write case number and proceed to Part III.		Head Start			Foster Child	Migrant	Runaway	Homeless
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PART II: Report Income for ALL Household Members. (Skip this step if participant is categorically eligible as documented in Part I.)		Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.								
A. Child Income ¹ ~ Sometimes children in the household earn or receive income. Please indicate the TOTAL		Child Income/How often? (i.e., weekly, monthly, etc.)								
Income received by child household members listed in PART I here.		\$ _____ / _____								
B. Other Household Members ² ~ List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I.		For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.								
Name of Other Household Members (First and Last)		1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?					
1.	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____						
2.	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____						
3.	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____						
4.	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____						
5.	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____						
C. Total Household Members (Adults and Children) listed in Part I and Part II										
Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). <i>Failure to complete this section, if income is listed, will result in denial of free or reduced eligibility.</i>										
Last four Digits of Social Security Number XXX-XX <input type="checkbox"/> I do not have a Social Security Number										
PART III: Enrollment Information Children Only										
My child is normally in attendance at the facility between the hours of _____ [am / pm] to _____ [am / pm] <input type="checkbox"/> (✓) Check here if only before/after school care is provided.										
Circle the days your child will normally attend the center: Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/>										
Circle the meals your child will normally receive while in care: Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack <input type="checkbox"/>										
PART IV: Signature										
I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. <i>If not completed fully and signed, the participant will be denied to the Paid category.</i>										
Signature: X _____ Print Name: _____ Date: _____										
Address: _____ City: _____ State: GA Zip: _____ Phone: _____										
*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and current design best practices identified by USDA through focus testing and other research.										
PART V: Participant's Ethnic and Racial Identities: The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.										
Check (✓) one ethnic identity: <input type="checkbox"/> Hispanic/Latin <input type="checkbox"/> Not Hispanic/Latin Check (✓) one or more racial identities: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiracial										
Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12										
Total Income: _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Year Household Size: _____										
Categorical Eligibility: check (✓) if applicable <input type="checkbox"/> Eligibility: check (✓) one Free <input type="checkbox"/> Reduced <input type="checkbox"/> Paid <input type="checkbox"/>										
Day Care Homes Only: check (✓) one Tier I <input type="checkbox"/> Tier II <input type="checkbox"/>										
When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy). Determining Official's Signature: _____ Date: _____										
Confirming Official's Signature: _____ Date: _____										
Follow Up Official's Signature: _____ Date: _____										

Non-Compete Agreement for Childcare Services

By enrolling my child (ren) at For the Love of Kids, I understand and agree to the following terms regarding non-solicitation of For the Love of Kids employees for external childcare services.

Prohibited Solicitation:

Parents, guardians, or any associated individuals shall not solicit, employ, or engage For the Love of Kids employees to provide private babysitting, nanny services, or any form of childcare for enrolled or formerly enrolled children, without prior written consent from For the Love of Kids.

Duration:

This restriction applies during the period in which the child(ren) are enrolled at For the Love of Kids and for a period of 12 months following the termination of enrollment.

Penalty for Violation:

In the event of a breach of this agreement, the parent or guardian agrees to pay a penalty fee of \$5,000.00 to For the Love of Kids for each occurrence, to compensate for the impact on business operations and potential employee conflicts. This fee is not exclusive of other remedies For the Love of Kids may pursue.

Acknowledgment:

By signing this agreement, I acknowledge that this non-compete clause is necessary to protect the integrity of For the Love of Kids services and its workforce.

Exceptions:

For the Love of Kids may provide written consent for such arrangements under specific conditions, evaluated on a case-by-case basis.

Signature: _____

Parent Guardian Name: _____

Signature: _____

Date: _____

For the Love of Kids Representative: _____

Name: _____

Signature: _____

Date: _____

Authorization to Dispense External Preparations

591-1-1-20(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

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and 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 _____
Name of Facility _____

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 By _____ Date _____

Field Trip Permission Slip

During after-school care our class will be going on daily fieldtrips to Academy Spring Park.

Located at 3120 Conyers St SE Covington GA.

Please sign below if your child may participate in the field trip stated above.

I give _____ permission to attend the above field trip.

Parent or Guardian _____

Date: _____

Means of transportation: **For the Love of Kids** daycare van

I give my permission for _____ receive emergency medical treatment, in case of an emergency.

Please contact _____

Telephone number _____