

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:

123456789101112131415161718192021222324252627282930313233343536373839404142434445464748495051525354555657585960616263646566676869707172737475767778798081828384858687888990919293949596979899100

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 ~~\$15~~^{\$20} 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

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: _____

**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

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDIPIR 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.	Children 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)				
		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 - 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 - 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). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**
Last four Digits of Social Security Number XXX-XX-____ ☐ I do not have a Social Security Number

PART III: Enrollment Information

My child is normally in attendance at the facility between the hours of _____ [am / pm] to _____ [am / pm] ☒ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Circle the meals your child will normally receive while in care: Breakfast AM Snack Lunch PMA Snack Supper Evening Snack

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. **If not completed fully and signed, the participant will be placed in the Paid category.**

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 content design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: The use of ethnicity and race 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: ☐ Hispanic/Latin ☐ Not Hispanic/Latin

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ 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: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year Household Size: _____

Categorical Eligibility: check (✓) if applicable ☐ Eligibility: check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

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

INFANT FEEDING PLAN

Child's Full Name _____ Date _____

Date of Birth _____

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: (check all that apply)

Strained Foods ☐ Whole Milk ☐
Baby Foods ☐ Table Food ☐
Formula ☐ Other ☐

What type formula used, if applicable? _____

Amount and time of formula/breast milk to be given? _____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes ☐ No ☐ If yes, when? _____

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes ☐ No ☐ Parent Initials: _____

The child has reached the following developmental skills:

Can hold his/her head steady? Yes ☐ No ☐
Opens mouth/leans forward in anticipation of food offered? Yes ☐ No ☐
Closes lips around a spoon? Yes ☐ No ☐
Transfers food from front of the tongue to the back and swallows? Yes ☐ No ☐

Instructions for the introduction of solid foods _____

Food likes _____

Food dislikes _____

Allergies? (including any premixed formula) _____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

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

PARENT'S SIGNATURE: _____ Date: _____

Infant Affidavit

Name of Sponsor (if applicable) _____

Name of Provider/Center _____

Name of Infant: _____

Infant Date of Birth: _____

Name of Parent/Guardian: _____

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: _____

Center/provider will provide the following Iron-fortified infant cereal: _____

Center/provider will provide the following brand of infant foods: _____

Parents/Guardians,

Please check one of the following options below and sign this form:

_____ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

_____ I will provide the following meal component to my infant and the center will provide all other meal components:

☐ Formula*

☐ Meat/Fish/Poultry/Eggs/Beans/Peas

☐ Cereal

☐ Cheese/Cottage Cheese/Yogurt

☐ Fruit

☐ Bread/Crackers/Breakfast Cereal

☐ Vegetable

Parent/Guardian Signature

Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.