Enrollment Agreement

VICTORY KIDS' ACADEMY

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information

Child's Information

Child's first name	Child's middle name	Child's last name	Child's nickname
Age / Sex	Child's primary language	Parent/guardian/sponsor primary language	
Child's home address	City	State	Zip
Does your child attend school? ☐ Yes ☐ No	School name	Grade	School phone
School address	Drop off time	Pick up time	

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone
Home address if different from above	City	State	Zip
Home email	Work email	Work phone	
Employer	Employer address	City / State / Zip	Work hours
Other parent/guardian/sponsor	Relationship to child	Home phone	Cell phone
Home address if different from above	City	State	Zip
Home email	Work email	Work phone	
Employer	Employer address	City / State / Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]

Person #1	Relationship to child	Home phone	Cell phone
Home address	City	State	Zip
Home email	Work email	Work Phone	
Employer	Employer address	City / State / Zip	Work hours
Person #2	Relationship to child	Home phone	Cell phone
Home address	City	State	Zip
Home email	Work email	Work Phone	
Employer	Employer address	City / State / Zip	Work hours
Person #3	Relationship to child	Home phone	Cell phone
Home address	City	State	Zip
Home email	Work email	Work Phone	
Employer	Employer address	City / State / Zip	Work hours

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial _____ Staff initial _____ Date _____

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Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color

Distinguishing marks

Child's Medical & Developmental History

1. Does your child have any special medical conditions? □ No □ Yes Explain
2. Does your child have any chronic illnesses? □ No □ Yes Explain
3. Please list a brief history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? □ No □ Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma? □ No □ Yes *If yes, please attach care instructions from your physician.*
6. Will medication be administered regularly? □ No □ Yes *If yes, please attach care instructions from your physician.*
7. Does your child have any special dietary needs? □ No □ Yes Explain
8. Is your child able to fully participate in all activities? □ Yes □ No Explain
9. Does your child have any physical restrictions? □ No □ Yes Explain
10. Does your child function at the level of other children in his/her age group? □ Yes □ No Explain
11. Is your child able to walk □ Yes □ No
12. Can your child communicate his/her needs? □ Yes □ No
13. Does your child need assistance at meal time? □ No □ Yes Explain
14. Does your child rest during the day? □ No □ Yes
15. Is your child toilet trained? □ No □ Yes
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? □ No □ Yes Explain
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? □ No □ Yes Explain
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? □ No □ Yes Explain

Illness History *(please check all that apply)*

□ Vision problems	□ Nosebleeds	□ Seizures
□ Hearing problems	□ Skin rashes	□ Mouth sores
□ Constipation	□ Sore throats	□ Fainting
□ Diarrhea	□ Ear infections	□ Persistent cough
□ Asthma/breathing problems	□ Urinary tract infections	□ Other

Please attach care instructions from your physician for any of these illnesses.

Disease History *(please check all that apply and add the date)*

□ Chicken Pox (Varicella)		□ Bronchiolitis		□ Botulism	
□ Measles Rubeola		□ Pneumonia		□ Haemophilus Influenza	
□ Rubella (German Measles)		□ Pertussis (Whooping cough)		□ Meningococcal Infection	
□ Mumps		□ Tetanus		□ Rabies	
□ Scarlet Fever		□ Diphtheria		□ Bacterial Meningitis	

Allergies *(please list)*

Medication Allergies	Reaction	**Food** Allergies	Reaction
Bee Stings Allergies	Reaction	**Respiratory** Allergies	Reaction
Other Allergies	Reaction	**Are any of these allergies life-threatening?**	□ **Yes** □ **No**

Please attach care instructions from your physician for any life-threatening allergies.

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

□ Vision		□ Developmental		□ Tuberculosis (PPD)	
□ Hearing		□ Aptitude		□ Sickle Cell Anemia	
□ Speech		□ Educational		□ Other	

To the best of my knowledge the information contained above is accurate.

Parent initial _____ Staff initial _____ Date _____

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Medical Information (continued)

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Primary physician's practice name		Phone
Physician's practice address	City	State	Zip
Preferred hospital/clinic for emergency care	City		State
Dentist's name	Dentist's practice name		Phone
Dentist's practice address	City	State	Zip

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received.

Anthrax	Influenza	**Pneumococcal disease**	**Smallpox**
Diphtheria	**Lyme Disease**	**Polio**	**Tetanus**
Haemophilus Influenzae type b (Hib)	**Measles**	**Rabies**	**Tuberculosis**
Hepatitis A	**Meningococcal disease**	**Rotavirus**	**Typhoid Fever**
Hepatitis B	**Mumps**	**Rubella**	**Varicella (Chickenpox)**
Human Papillomavirus (HPV)	**Pertussis (Whooping Cough)**	Shingles (Herpes Zoster)	**Yellow Fever**

Additional Medical Policies

	Initial
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*. 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.	

Emergency Medical Authorization & Consent

	Initial
In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.	
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a Phoebe Putney other urgent care facility, if necessary, by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

	Initial
I give my permission to this center to apply □ sunscreen and □ insect repellant to my child. *Please check which products you will permit.*	
I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	
I □ have □ do not have special instructions for the application process. _____	

Parent initial _____ Staff initial _____ Date _____

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

Breakfast

Morning Snack

Lunch

Afternoon Snack

Evening Snack

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 allergic to: _____

At a special request could the Academy_____

Please take a brief moment to tell us about your child. Please let us know any information that will help us in caring for your child.

Victory Kids' Academy 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. _____

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