



Kids' Zone

Daycare & Learning Center

Children's Enrollment Form

Entrance Date

Withdrawal Date

Main E-Mail

Child's Name

Sex

Age

Birthdate

Home Address

Home Phone Number

Father's Name

Home Address/Phone Number (If different from child's)

Place of Employment/Address of Employment/ Business Number

Mother's Name

Home Address/Phone Number (If different from child's)

Place of Employment/Address of Employment/ Business Number

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

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

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

| <u>Name</u> | <u>Relationship to child</u> | <u>Address (include phone #, complete street address, city, state, and zip code)</u> |
|-------------|------------------------------|--|
| | | |
| | | |
| | | |

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

Name

Telephone Number

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

Physician/Clinic's Telephone Number: _____

My child has the following special need(s): **NO YES (see below)**
(circle one)

The following special accommodation(s) may be required to most effectively meet my child's needs while at this center (include religious preferences): **NO YES (see below)**
(circle one)

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:

NO YES (see below)
(circle one)

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

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



Kids' Zone

Daycare & Learning Center

Parental Agreement

1. 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 Morning Snack 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 childcare 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.
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 child attends. (See handbook for exceptions).
10. Parent and Kids' Zone agree to provide a 2-week written notice to terminate this contract. 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.

Signature (Parent or Guardian) _____ Date _____

Signature (Director/Assistant) _____ Date _____

Vehicle Emergency
Medical Information



Kids' Zone
Daycare & Learning Center

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home/Cell Phone _____ Work Phone _____

Mother's Name _____

Home/Cell Phone _____ Work Phone _____

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

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medial 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 by _____ Date _____



Medical Care and Emergency Contact Information

Child's Name: _____ Birth Date: _____

Address: _____

Mother's Name: _____ Phone (H) _____ Phone (W) _____

Father's 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, 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 # _____

Notarized 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 Learning Center to transport my child to the emergency room of the hospital(s) listed below, 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 - Kennestone Hospital _____ Hospital

Parent/Guardian Date Parent/Guardian Date

State of: _____ County of: _____

The foregoing Consent was acknowledged before me this _____ day of _____, 20____

By _____ My Commission Expires: _____
Notary Public

Notary Seal

Food Allergy Action Plan



Student's Name: _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

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

Give Checked Medication**:

(To be determined by physician authorizing treatment)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side 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. Dr. _____ at _____

3. 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 _____



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 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



Website Photo Release Form

I, _____ (please print), grant permission to Kids' Zone Daycare & Learning Center to reproduce the photographs taken of my child(ren),

_____ or members of my family, for Kids' Zone's purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium.

I acknowledge that I am over the age of 18
 the legal guardian said child(ren)

Signature _____

Date _____

Address _____



Snapfish Photo Release Form

I, _____ (please print), _____ grant
(do, do not)
permission to Kids' Zone Daycare & Learning Center to post photographs taken of my
child(ren), _____ to a
Snapfish Account. This account is named Kids' Zone and the password will be provided only to families
enrolled at Kids' Zone.

I acknowledge that I am over the age of 18
 the legal guardian said child(ren)

Signature _____

Date _____