Kids 4 Kompany Learning Academy 615 Greison Trail Newnan, GA 30263 (770)502-9802 Phone (770)502-9808 Fax

	Enrollment	t Applicatio	n acces	s code	
Entrance Date	EMAIL ADD	RESS			_
Child's Full Name	DOB		Sex	Age	
Child's Address		City, State	Zip (Code Phone	#
Father's Name/ Address		City, State	Zip Code	Phone #	
Father's Place of Employme	nt/Address	City, State	Zip Code	Work #	
Mother's Name/ Address		City, State	Zip Code	Phone #	
Mother's Place of Employme	ent/Address	City, State	Zip Code	Work #	
Child lives with: Check one	() Both Paren	ts () Mother	() Father () Other	
List names of previous school	ol or childcare	center your ch	nild attended:		
List the name of the school y	our child curre	ntly attends:			

List all medications your child is currently taking:

Child's Doctor Name/Address

List all medical and food allergies your child has:

List all pre-existing health conditions or behavioral conditions for your child:

May we take photos of your child (all your children) in the learning environment settings for center use and promotional purposes only? [] Yes [] No

Name	Relationship	Address	Phone #

ADDRESSES MUST BE COMPLETE; THIS MAY NOT BE LEFT BLANK

In the event of an emergency and I cannot be reached, please contact:

Name	Relationship	Address	Phone #

ADDRESSES MUST BE COMPLETE; THIS MAY NOT BE LEFT BLANK

Signature _____

Date _____

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Parental Agreement

1. Kids 4 Kompany Learning Academy agrees to provide childcare for

Monday through Friday from 6:00am tochild's name6:00pm on a year round basis.

Infants and toddlers must be picked up by 5:00pm. My child will participate in the following meal plan: breakfast lunch afternoon snack or dinner.

- 2. 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.
- 3. 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.
- 4. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable diseases, which include my child.
- 5. Kids 4 Kompany 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.
- 6. I have received a copy and agree to abide by the policies and procedures for Kids 4 Kompany Learning Academy.

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Emergency Medical Authorization

Should ______, _____ suffer an

Child's Name

Date of Birth

injury or illness while in the care of Kids 4 Kompany Learning Academy and the facility is unable to contact me immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. The hospital Kids 4 Kompany Learning Academy utilizes is Southern Regional Hospital. (We) agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of healthcare is:

Physician/Clinic Name/Address

Physician's Telephone #

Known medical conditions (e.g.) diabetic, asthma, allergies:

Signed Date

Parent/Legal Guardian Name

Telephone # _____

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Transportation Agreement

Kids 4 Kompany Learning Academy will be providing routine transportation for ______ to and/or from school or from home to the childcare center.

(Please circle one)

Please specify the pickup and delivery locations as well as the time.

Routine pick up location and Time	
Routine delivery location and Time	
List the name of any person/s authorized to receive your child	

In the event that no one is present to receive your child, specify the procedure Kids 4 Kompany Learning Academy shall follow:

Name/Date of Authorized Signature

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Vehicle Emergency Medical Information

Child's Name/Address/ I	OOB	
Father's Name	Home Phone#	Work Phone #
Mother's Name	Home Phone #	Work Phone #
Person to notify in an em	ergency and parents cannot	be reached:
Name	Phone#	
Child's Doctor	Phone #	
•	ompany Learning Academy	utilizes is: nan, GA 30263
		<i>`</i>
	cation:	
	eeds and conditions:	
cannot get in touch with	me, I hereby authorize any n	f Kids4 Kompany Learning Academy eeded emergency medical care. I penses incurred during the treatment
Child's Name	Signature/Date of	of Parent/Guardian
Witnessed by:	Date	9

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Infant Feeding Plan

Child's Name	DOB	Date
Does the child take a b	ottle?	
Is the bottle warmed?		
Does the child hold ow	n bottle?	
Can the child feed self		
Place a check next to	all that apply	y. Does the child eat:
Strained foods		Whole Milk
Baby food		Table Foods
Formula		Other
What type of formula	used?	
Amount of formula to) be given? _	
Updated amounts of f	formula:	Date
		Date
Does the child take a When?	pacifier?	
Food likes		Food dislikes
Allergies (which inclu	ides any prei	nixed formula)
		Child's Schedule
Breakfast		
Time		Types and approximate amounts of food
Lunch		
Dinner		
Morning Nap/Afternoo	on Nap approx	ximate times:
		olid foods or regarding adding new foods please list:

Signature/Date of Parent/Guardian _____