



SRRC • Berry College • Rome City Schools

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 _____ Work Phone _____

Employer'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 _____ Work Phone _____

Employer'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

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) _____

Persons to contact and can pick up in the case of emergency if parent or guardian cannot be reached:

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) _____

Name _____ Address _____
(Street-City-State-Zip)

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

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: _____ **Date:** _____

Signature

Facility Administrator/Person-In-Charge _____ **Date** _____

Signature

Parental Agreements with Child Care Facility

The South Rome Early Learning Center agrees to provide day care for

_____ on Monday through Friday from 7:30 a.m. to 3:30 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 South Rome Early Learning Center 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 childcare 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 the South Rome Early Learning Center.

I understand that the center 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)

VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____ Home Phone Number _____

Work Phone Number _____ Cell Phone Number _____

Mother's Name _____ Home Phone Number _____

Work Phone Number _____ Cell Phone Number _____

Person to notify in case of an emergency when parents cannot be reached:

Name _____ Phone Number _____

Child's Doctor _____ Phone Number _____

Medical Facility the Center uses Floyd Medical _____.

Address 304 Turner McCall Blvd, Rome, GA 30165 _____.

Child's Allergies _____

Current prescribed medication _____

Child's special medical needs and conditions _____

In the event of an emergency involving my child's, and if the South Rome Early 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 mu child.

Child's Name _____

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____

Witnessed by _____ Date _____