South Rome Early Learning Center

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 n 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 tough 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 _____