KEEPING IT POSITIVE LEARNING ACADEMY L.L.C.
1920 VETERANS MEMORIAL HWY
AUSTELL, GA 30168
PHONE: 770-672- 7800
FAX: 770-672-7801

Entrance Date:_____ Withdrawal Date:_____

Child's Name:_____

Sex: F / M Age: _____ D.O.B: ____/____/____

Street Address:_____ City/State:_____ Zip:_____

Home Phone: (_____)-_____-_____ (Go-to) Cell Phone: (_____)-_____-_____

Mother -

Mother's Name: _____ Mother's Cell (_____) _____-_____

Address (If different than child's address): _____ City/State:_____ Zip:_____

Mother's Place of Employment:_____ Work Phone: (_____) _____-_____

Employer's Address:_____ City/State:_____ Zip:_____

Mother's Email Address: _____

Father -

Father's Name: _____ Father's Cell (_____) _____-_____

Address (If different than child's address): _____ City/State:_____ Zip:_____

Father's Place of Employment:_____ Work Phone: (_____) _____-_____

Employer's Address:_____ City/State:_____ Zip:_____

Father's Email Address: _____

Child's Living Arrangements (select one): Both Parents [_] Mother [_] Father [_] Other [_]

Child's Legal Guardian(s) (select one): Both Parents [_] Mother [_] Father [_] Other [_]

I agree that the following person(s) listed and I can release (child's name) _____ from KIPLA grounds.

Name: _____ Address:_____ City/State:_____ Zip: _____

Relationship to child: _____ Telephone Number: (_____) _____-_____

Name: _____ Address:_____ City/State:_____ Zip: _____

Relationship to child: _____ Telephone Number: (_____) _____-_____

Signature: _____ Date: _____/_____/_____

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Person(s) to contact in the case of emergency when parent or guardian cannot be reached:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Name of Public or Private School child attends, if any:

_____

Child's doctor or clinic name:

_____

Doctor/Clinic Phone Number: (_____) _____-_____

My child has the following special needs:

_____
_____
_____

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) _____ (D.O.B.) _____/_____/_____ suffer and injury or illness while in care of _Keeping It Positive Learning Academy_ and _Keeping It Positive Learning Academy_ 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 service.

Parent/Guardian: _____

Signature

Date: ____/_____/_____

Facility Administrator/ Person-In-Charge: _____

Signature

Date: ____/_____/_____

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Parents Agreements with Keeping It Positive Learning Academy

Keeping It Positive Learning Academy agrees to provide child care for (child's name) _____

on (days of the week) _____ a.m. to _____p.m.

from (month) _____ to (month) _____

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

Breakfast / Lunch / Afternoon Snack / Dinner

- Before any medication is dispensed to my child, I will provide a written authorization, which includes: name of child, name of medication, prescription number, (if any) dosages, and the time of day medication is to be given. Medicine will be in original container with child's name marked on it.
- My child will not be allowed to enter or leave Keeping It Positive Learning Academy without 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 immuzation records, etc.
- Keeping It Positive Learning Academy agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from Keeping It Positive Learning Academy, and water-related activities occurring in water that is more than two (2) feet deep.
- I authorize Keeping It Positive Learning Academy to obtain emergency medical care for my child, when I am not available.
- I received a copy and agreement to abide by the polices and procedures given by Keeping It Positive Learning Academy.

I understand that the facility 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.

Parent Signed: _____ Date: ____/_____/_____

Administrator Signed: _____ Date: ____/_____/_____

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Child and Adult Care Food Program

Enrollment Statement

_____	____/____/____	_____
Name of child or Adult	**D.O.B.**	**Age**
_____	____/____/____	_____
Name of child or Adult	**D.O.B.**	**Age**
_____	____/____/____	_____
Name of child or Adult	**D.O.B.**	**Age**
_____	____/____/____	_____
Name of child or Adult	**D.O.B.**	**Age**
_____	____/____/____	_____
Name of child or Adult	**D.O.B.**	**Age**

Is enrolled at :

_____
_____

Name of Child or Adult Day Care Center

Address of Child or Adult Day Care Center

My child or adult is normally in attendance at the facility between the hours of _____ am/pm to _____ am/pm on the following days: (Circle all that apply). [_] Check here if only before/after school care provided. Sunday Monday Tuesday Wednesday Thursday Friday

My child will normally receive the following meals while in care (Circle all the apply):

Breakfast Lunch Pm Snack Dinner

Beginning on _____ Date: ____/____/____

Signature _____ Date: ____/____/____

In the operation of USDA's food service program, no one will be discriminated against because of race, color, national origin, sex, age or disability. If you believe you have been discriminated against, write to: Administrator, Food Consumer Service, U.S. Department of Agriculture, 3101 Park Center Drive, Alexandria, VA 21302

For Center Use Only

Participant withdrawn on (Date) : _____

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General Release Form

I verify the above information to be correct and thus I hereby grant permission for the information provided in the preceding Registration Form to be distributed to KIPLA providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by KIPLA providers or DECAL which shall include, but not be limited to the Georgia Department of Education, and colleges/universities.

Signature (Parent/Guardian): _____

Date: ____/_____/_____

Photograph/Videotape Release Form

I hereby grant permission for the KIPLA provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the KIPLA provider or DECAL which shall include, but not be limited to, the Georgia Department of Education,, and colleges/universities, to record the participation and appearance of my child, _____. By photograph and/or videotape in connection with daily KIPLA activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape(s) in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape(s) may, for example, appear in printed or visual materials for DECAL and/or on DECAL's website.

The undersigned hereby jointly and severally releases: acquits, forgives, and discharges the KIPLA provider, DECAL, and other entities contracted by the KIPLA provider or DECAL, from any actions, agreements, claims, controversies, demands, judgements, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to extent permitted by law.

Provider Name/Address: KIPLA / 1920 Veterans Memorial Hwy, Austell, GA 30168

Signature (Parent/Guardian): _____

Date: ____/____/____