Kat's Little Angels

Enrollment Package
Please Fill out everything, if it does not apply please put N/A.

CHILDREN'S 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 Social Security #_____
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 Social Security #_____
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_____

Email Address_____
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 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#_____

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 MEDICALAUTHORIZATION

Should (child's name)_____Date of birth_____ suffer an injury or illness while in the care of (Facility name) Kat's Little Angels Daycare 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:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Kat's Little Angels
Parental Agreements with Child Care Facility

The Kat's Little Angels agrees to provide child care for
(Name of Facility)
_____ On Monday- Sunday 6 a.m.to 11:59 p.m.
(Name of Child) (Days of Week)
from January to December .
(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, adversary actions to medications, etc., which include my child.

The **Kat's Little Angels** agrees to obtain written authorization from me before my child participates in routine transportation, fieldtrips, special activities away from the facility, and water-related activities so curing in water that is more than two (2) feet deep.

I authorize the child care 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
Kat's Little Angels.
(Name of Facility)

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.

Signed:_____ Date:_____
(Parent/Guardian)

Signed:_____ Date:_____
(Facility Administrator/Person-In-Charge)

Kat's Little Angels

Safe Sleep Practices Policy

Child's Name: _____ Date of birth: _____

Parent/Guardian Name: _____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice: __ Bedding for cots/mats will be laundered daily _

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

Kat's Little Angels
Transportation Agreement

This is to certify that I give _____**Kat's Little Angels**_____
Name of Facility

Permission to transport my child _____
Name of Child

from _____ at _____ (am/pm)
Pickup Location

to _Kat's Little Angels_____ at _____(am/pm).
Delivery Location

My child will be transported from _____at _____(am/pm)

to _____ at _____(am/pm)
Delivery Location

on the following days:

_____ Monday
_____ Tuesday
_____ Wednesday
_____ Thursday
_____ Friday

_____ is authorized to receive my child. In the event the authorized Name of Authorized Person

person is not presented to receive my child; the following procedures are to be followed:

_____

_____

_____

The _____is approximately _____ miles from the center.
Location
In the event that my child is not to be transported as outlined above, I agree to notify the

___***Kat's Little Angels***_____.
Facility

Signature (Parent/Guardian) _____ Date _____

Kat's Little Angels

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

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

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical 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 _Kat's Little Angels_____
Name of Facility

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 _____

INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?_____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula)_____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods_____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

Permission to Photograph

I, _____, give permission for Kat's Little Angels Daycare to
(Parent or Guardian name) (Child Care Provider)

photograph my child, _____, for the following purposes:
(Child's name)

Type of Use:	(Please check one)	
	Grant Permission	**Decline Permission**
Still Photographs:		
Display in my personal scrapbook		
Give photographs possibly containing your child to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on child care website*		
Post photos on child care's Facebook page		
Other:		
Videos:		
Give video to current parents		
YouTube™ promotional video		
Other:		
Other (please list):		

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

_____ _____
(Parent or Guardian signature) (Date)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental 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 _Kat's Little Angels_____, 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

*center should maintain in child's file

KAT'S Little Angels Daycare

Infant Supply List

☐Prepared bottles
☐Pacifiers
☐Diapers
☐Wipes
☐Diaper ointment
☐Extra Clothes (uniforms- black or navy-blue shirt "solid color" & Khaki or Black Pants)
☐Extra formula (ready-made formula for emergency use only, we cannot mix formula)
☐Diaper bag (enough space to store empty bottles and clothes that may be sent home)

Please Remember:

- Please label all items with child's first and last name.
- All creams and sunscreens to be applied require a completed medical authorization form and must be kept in their original containers with your child's full name on it.
- All prescriptions must be in the original containers with the patient's name, dosage and prescribed time to be given. The doctor must complete a medical form before medication can be administered.
- Any over the counter medications (Tylenol, Motrin, etc.) require a permission form from your doctor which must include the proper dosage for your child's weight, age and the reason why it is to be administered. This medication cannot be given no more than two weeks.

Parents or Guardian's
Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, Kats Little Angels, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____
Parents or Guardian's Signatures **Date**

_____ _____
Parent or Guardian (Print Names) **Date**

Kathy Bligo _____
Center Director's Signature **Date**

Bright from the Start: Georgia Department of Early Care and Learning
Child and Adult Care Food Program
Income Eligibility Statement

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A: A. Name (List everyone in household, including foster and non-foster children)	B. Gross income and how often it is received. Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
6. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
7. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐

PART III: ENROLLMENT INFORMATION: ***Children Only***

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm] on the following days:
☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:
(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult MUST sign).

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care .

Signature: X_____ **Print Name** _____ **Date:**_____

Address: _____ **City:** _____ **State: GA Zip:**_____ **Phone:** _____

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year **Household Size:** _____

Categorical Eligibility: (check if applicable) _____ **Date withdrawn:** _____ **Eligibility:** (check one) Free _____ Reduced _____ Paid _____

Day Care Homes Only: (check one) Tier I _____ Tier II _____

Determining Official's Signature: _____ **Date:**_____

Confirming Official's Signature: _____ **Date:**_____

Follow Up Official's Signature: _____ **Date:**_____

10/2017