Prepping for Excellence Academy
Student 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 in the case of emergency when parent or guardian cannot be reached:

Name_____Phone #(s)_____

Name_____Phone #(s)_____

Name_____Phone #(s)_____

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:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Parental Agreements with Child Care Facility

The Prepping for Excellence Academy agrees to provide day care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ 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 _____ 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 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
_____.
(Name of Facility)

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)

DECAL SAMPLE

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:

_____

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_____

MEDICATION AUTHORIZATION

Child's Full Name_____

Name of Medication_____

Prescription Number_____

Time Medication is to be Given_____

Amount of Medication to be Given_____

Date(s) to be Given_____

_____ _____

Signature of Parent or Guardian Date

For Center Use

	Date	Time Given	Amount	Any Adverse Reactions	Administered By
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

If noticeable adverse reaction to medication what action was taken? Describe.

_____

_____

_____

_____

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:** _____