EARLY BIRDS ACADEMY

678-540-8790

muyiwalk@yahoo.com

363 COBB PARKWAY
S.MARIETTA GA 30060

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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:		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:

_____

_____

_____

_____

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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: _____

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Parental Agreements with Child Care Facility

The _____ agrees to provide childcare 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 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

_____
(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)

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All about me!

The child profile will help our teachers get to know their new friends.

My first name is _____

and my last name is _____

Everyone calls me _____

My birthday is _____. I am _____ Years old.

I am allergic to _____

These are the people who live in my house:

Name	Relationship	Age

I can't wait to come to school because: _____

My favorite activities at home are _____

My Parents/Guardians would like you to know this about me:

_____

_____

_____

My Parents/Guardians are most looking forward to me learning about:

_____

_____

_____

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Authorization to Dispense External Preparations

590-1-.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.

Child's Name _____ D.O.B _____

I give _____ 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 first aid spary
- ☐ Sunscreen
- ☐ Insect Repellent
- ☐ Non-Prescription ointment (such as A & D, Destion, Vaseline)
- ☐ Baby powder
- ☐ Other(Please specify): _____

Specific Terms of Use: _____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

CENTER USE ONLY!

☐ Child's file

_____ _____

Director's Signature Date

ILLNESS CHART

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For the safety of all children and staff, please note that if your child exhibits any of the following symptoms listed below, they will not be able to attend.

SYMPTOMS	WAIT DURATION
Fever (+101)	48 hours, with normal temp
Vomiting	24-48 hours, with no symptoms
Chicken Pox	5-6 days, with completed healed lesions
Conjunctivitis	24 hours after treatment
Head Lice	2 weeks after exposure with full extermination
Diaper Rash	Until all open sores are healed
Impetigo	Until all lesion are healed.
Ringworm	Until all lesions/rashes are healed
Strep-Throat	Until 24 hours, on medication with no fever.
Measles	7 days after appearance of rash, healed.
Mumps	Until all swelling is gone.
Hooping Cough	Until physician clears.
COVID-19	5 days with Quarantine.

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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MINOR (CHILD) PHOTO RELEASE FORM

I,_____, the parent or legal guardian of _____[Child] grant **Early Birds Academy** my permission to use the photographs described as **photos and video recordings of child care center activities** for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Furthermore, I understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Child's Name: _____

Parent/Guardian Name: _____

Phone: _____

Parent/Guardian Signature _____ Date: _____