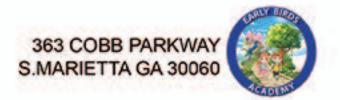


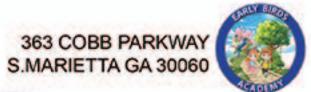
- 678-540-8790
- muyiwalk@yahoo.com
- 363 COBB PARKWAY S.MARIETTA GA 30060



Madrida		
Address (Street-City-State-Zip):		_
Telephone Number:	Relationship to child:	
Relationship to Parent(s) or Gua	rdian:	
	ny):	
		100
Persons to contact in the case	of emergency when parent or guardian cannot be re	eached:
Name:	Telephone Number:	
Name of Public or Private School	I child attends, if any:	
Name of Public or Private School Child's doctor or clinic name: Doctor/clinic phone #		
Name of Public or Private School Child's doctor or clinic name: Doctor/clinic phone # My child has the following specia	Contra	

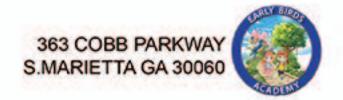


EMERGENCY MEDICAL AUTHORIZATION		
Should (child's name)	Date of birth	suffe
an injury or illness while in the care of (Facility name) _	- 571.75V.V.54.181	and
the facility is unable to contact me (us) immediately, it sha	all be authorized to secure such	medical attention
and care for the child as may be necessary. I (We) shall	assume responsibility for payn	nent for services.
Parent/Guardian:		
	Signature	
Date:		
Facility Administrator/Person-In-Charge:		
ravinty raminouatour croon-in-onarge.	Signature	
Date:		



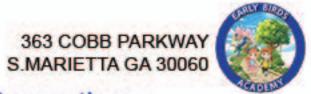
Parental Agreements with Child Care Facility

The		agrees	to provide childcare for
(Na	ame of Facility)		
	on	a.m. to	p.m.
(Name of Child)	(Days of Week)		
From	to		
(Month)	(Month)		
My child will participate in	n the following meal plan	(circle applicable meals and	snacks);
□Breakfast	I SUSPENDENT SELECTION ASSESSMENT	☐ Evening Snack	2. C-4.0 (1) 4 2
☐ Morning Snack		Dinner	
Lunch		☐ Bedtime Snack	
☐ Afternoon Snack			
parent (s), or facility pers reflect any significant of contacts, child's physicia	onnel. I acknowledge it is hanges as they occur, on, child's health status, in the informed of any incide include my child.	being escorted by the parent is my responsibility to keep my e.g., telephone numbers, we fant feeding plans and immu- ents, including illnesses, injur- agrees to obtain writter	child's records current to ork location, emergency nization records, etc. The ies, adverse reactions to
before my child participa and water-related activitie facility to obtain emerger and agree to abide by the	ites in routine transportations occurring in water that	ion, field trips, special activiti is more than two (2) feet deep child when I am not available	es away from the facility, b. I authorize the childcare
(Name of Facility)			
	al practices concerning r	child's progress and issues r my child's special needs. I	
Signed:		Date:	
(Parent/Guardian)			
Signed:		Date:	
(Encility Administrates/Do	ereon In Charge)	5000.	



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:



Authorization to Dispense External Preparations

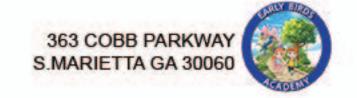


590-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or nonprescription 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	
	Permission to apply one or more ns to my child in accordance with the directions on	
□Baby wipes □Band Aids	☐ Insect Repellent ☐ Non-Prescription ointment (such as A &	
□ Neosporin or similar first aid spary □ Sunscreen	D, Destion, Vaseline) Baby powder	
Other(Please specify):	27.5600.03 xerc 27.	
Specific Terms of Use:		
Parent/Guardian Signature	Date	
CENTER USE ONLY!		
□ Child's file		
Director's Signature	Date	

ILLNESS CHART





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.





Automated Payment Processing Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express*-a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

	d account (Section A) OR, init	tiate debit entries to my (our) che on of this agreement, I (we) are		count,
	please contact your credit unio	n to verify account and routing r		
COMPLETE ONE SECTION O	NLY			
SECTION A (Ends Card)				
Cardholder Name		Phone #		
Cardholder Address		City	State	Zip
Account Number		Expiration Date		
Cardholder Signature			Date	
SECTION B (Bank Assount)				
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 b	elow)	Account Number (see sample belo	w) Checking	g Savings
Authorized Signature			Date	
For Official Use Only	John Sample Mary Sample	BENN OF THE WEST 313-333-3553	00226	service of
Date Received	123 Nice Street Anytown, USA			
Employee Signature	order of:	Voided Check Here s	ters [orocare
	C1234557891 1900338P	0226 Chera Number		SOFTWARE®

MINOR (CHILD) PHOTO RELEASE FORM

l,	
	[Child] grant Early Birds
Academy my permission to use the photograph	s described as photos and video recordings
of child care center activities for any lega	I use, including but not limited to: publicity,
copyright purposes, illustration, advertising, and	web content.
Furthermore, I understand that no royalty, fee o to me by reason of such use.	r other compensation shall become payable
Child's Name:	
Parent/Guardian Name:	
Phone:	
Parent/Guardian Signature	Date: