Children Unique
Christian Daycare Center

# Enrollment Application

Enrollment Date ____________ Withdrawal Date _____________

Child's Name ______________________ Sex ____ Age___Date of Birth ______________

Home Address (Street) ________________City ______________State_______Zip _________

**Father/Guardian Information**

Name _____________________________

Home Phone ______

Address ___________________________

___________________________

Social Security No. __________________

Employer __________________________

Employer Address ___________________

___________________

Employer Phone _____________________

**Mother/Guardian Information**

Name ___________________________

Home Phone ______________________

Address _________________________

_________________________

Social Security No. ________________

Employer ________________________

Employer Address__________________

__________________

Employer Phone ___________________

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 _____________________

*Name ____________________ Address ______________________________________________
(Street-City-State-Zip)

Telephone # _____________________ Relationship to child _____________________

*Name ______________________ Address ________________________________________ ______
(Street-City-State-Zip)
Telephone # ______________________ Relationship to child ______________________

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name______________________________Telephone # ____________________________

Name______________________________Telephone # ____________________________

Name______________________________Telephone # ____________________________

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:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Please note that weekly fees are due by Wednesday of each week and a late fee of $25.00 may be applied the following Thursday.

By signing below you agree that in the event that your account is transferred to collections due to non-payment, you will be responsible for up to 50% of collection fees and all legal fees.

_______________________________________ ________________________
Signature Date

## EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) __________________ Date of Birth__________________suffer an injury or illness while in the care of ***Children Unique*** 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 *ChildrenUnique*

Children Unique agrees to provide child care for ______________________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
Dinner

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 illness, injuries, adverse reactions to medications, etc., which include my child.

Children Unique agrees to obtain written authorization from me before my child participates in routine transportation, field trips, and special activities away from the facility.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

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.

By signing below I agree to abide by Children Unique's policies and procedures listed in the 'Parent Handbook' that I have accessed and reviewed/obtained at http://childrenunique.com/cucdc-forms-documents.html .

Signed:___________________________________Date: ___________________
(Parent/Guardian)

Signed:___________________________________Date: ___________________
(Facility Administrator/Person-In-Charge)

**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 _____________

Does the child take a pacifier? Yes [ ] No [ ]

If yes, when? ____

Food likes ______

Dislikes ______________________________________________________________

Allergies? (Include any premixed formula) _____________________________________

**Formula/Breastmilk** **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 ______________________

Children Unique

Christian Daycare Center

**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 that Richmond Co. centers use: **GEORGIA REGENTS HEALTH**

Address of Medical Facility: **1120 15th St. Augusta, Ga. 30912**

Medical Facility that Columbia County centers use: **DOCTOR'S HOSPITAL**

Address of Medical Facility: **3651 Wheeler Rd. Augusta, Ga. 30909**

Child's Allergies _________________________________________________________

Current prescribed medication ______________________________________________

____________________________________________________________________

Child's special needs and conditions _________________________________________

____________________________________________________________________

In the event of an emergency involving my child, and if Children Unique 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.

Signature (Parent/Guardian) _________________________________________________

Date ______________________________

Children Unique
Christian Daycare Center

**Transportation Agreement**

This is to certify that I give Children Unique Christian Daycare Center permission to transport my child___________________________________from

Name of Child

____________________________________ at___________________( a.m. / p.m.) to

Pickup Location Time

____________________________________ at___________________(a.m. / p.m.).

Delivery Location Time

My child will be transported from______________________________at (a.m. / p.m.) to

Pickup Location

___________________________________ at______________________(a.m. / p.m.) on

Delivery Location Time

the following days:

____________________________________ Monday

____________________________________ Tuesday

____________________________________ Wednesday

____________________________________ Thursday

____________________________________ Friday

Signature (Parent/Guardian) _________________________________________________

Date ________________________________

Children Unique
Christian Daycare Center

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_______________________________________________, 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**

# Children Unique
## Christian Daycare Center

From the desk of …
Janie M. Davis
CEO/Owner

Parents,

From time to time Children Unique may attend field trips where media is present, or others may be present that are recording or taking pictures. In addition, we routinely like to photo the children to display at the center as well as conferences or classes for which Children Unique Christian Daycare Center, Inc. is representing.

Additionally, we like to include digital photos of our children's activities on our website.

Please indicate below whether or not you give permission for your child to be taped or photographed. Depending on the function, the media may want to address the children. Only first names will be used when applicable.

________Yes, my child may be taped or photographed.

________No, my child may not be taped or photographed.

Student's Name: ________________________________________

Classroom: ____________________________________________

Parent/Guardian Signature: _______________________________

Date: ______________________

Email: uniquekids@aol.com

Company Website: www.childrenunique.com

**Bright from the Start: Georgia Department of Early Care and Learning**
**Child 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 — 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Social Security, pensions, retirement | 4. All other income | C. Check if NO 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.*

**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 or Latino<br>☐ Not Hispanic or Latino | ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native<br>☐ Native Hawaiian or other Pacific Islander |

**Official Use Only: 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: ______ Date withdrawn ____________ Eligibility: Free _____ Reduced _____ Paid _____ Tier I _____ Tier II _____

Temporary: Free _____ Reduced _____ Time Period: ______________ (expires after ______days)

Determining Official's Signature: ______________________ Date______________

Confirming Official's Signature: ______________________ Date______________

Follow Up Official's Signature: ______________________ Date______________

2/2011