

Enrollment Agreement

Rainbow Academy of Learning

4177 Rainbow Drive
Decatur, GA 30034
404-534-9379

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information

Child's Information

Child's first name		Child's middle name		Child's last name		Child's nickname	
Age	Sex	Child's primary language		Parent/guardian/sponsor primary language			
Child's home address			City		State		Zip
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Grade		School phone	
School address			Drop off time		Pick-up time		

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Home email		Work email			Work phone		
Employer	Employer address		City		State		Zip
Work hours							
Other parent/guardian/sponsor		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Home email		Work email			Work phone		
Employer	Employer address		City		State		Zip
Work hours							

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]

Person #1		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State		Zip
Work hours							
Person #2		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State		Zip
Work hours							
Person #3		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State		Zip
Work hours							

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial _____ Staff initial _____ Date _____

Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks _____

Child's Medical & Developmental History

1. Does your child have any special medical conditions? No Yes Explain _____

2. Does your child have any chronic illnesses? No Yes Explain _____

3. Please list a brief history of your child's serious injuries and hospitalizations. _____

4. Does your child have diabetes? No Yes *If yes, please attach care instructions from your physician.*

5. Does your child have asthma? No Yes *If yes, please attach care instructions from your physician.*

6. Will medication be administered regularly? No Yes *If yes, please attach care instructions from your physician.*

7. Does your child have any special dietary needs? No Yes Explain _____

8. Is your child able to fully participate in all activities? Yes No Explain _____

9. Does your child have any physical restrictions? No Yes Explain _____

10. Does your child function at the level of other children in his/her age group? Yes No Explain _____

11. Is your child able to walk Yes No

12. Can your child communicate his/her needs? Yes No

13. Does your child need assistance at meal time? No Yes Explain _____

14. Does your child rest during the day? No Yes

15. Is your child toilet trained? No Yes

16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc? No Yes Explain _____

17. Does your child require on-to-one care/supervision on a regular basis for a significant period of time? No Yes Explain _____

18. Does your child require any accommodations or modifications to fully and equally enjoy and participated in a group care setting?
 No Yes Explain _____

Illness History *(please check all that apply)*

<input type="checkbox"/> Vision problems	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sore throats	<input type="checkbox"/> Fainting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Urinary track infections	<input type="checkbox"/> Other

Please attach care instructions from your physician for any of these illnesses.

Disease History *(please check all that apply and add the date)*

<input type="checkbox"/> Chicken Pox (Varicella) _____	<input type="checkbox"/> Bronchiolitis _____	<input type="checkbox"/> Botulism _____
<input type="checkbox"/> Measles Rubeola _____	<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Haemophilus Influenza _____
<input type="checkbox"/> Rubella (German Measles) _____	<input type="checkbox"/> Pertussis (Whooping cough) _____	<input type="checkbox"/> Meningococcal Infection _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Rabies _____
<input type="checkbox"/> Scarlet Fever _____	<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Bacterial Meningitis _____

Allergies *(please list)*

Medication Allergies	Reaction	Food Allergies	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
Bee Stings Allergies	Reaction	Respiratory Allergies	Reaction
_____	_____	_____	_____
Other Allergies	Reaction	Are any of these allergies life-threatening? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	_____		

Please attach care instructions from your physician for any life-threatening allergies...

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

<input type="checkbox"/> Vision _____	<input type="checkbox"/> Developmental _____	<input type="checkbox"/> Tuberculosis (PPD) _____
<input type="checkbox"/> Hearing _____	<input type="checkbox"/> Aptitude _____	<input type="checkbox"/> Sickle Cell Anemia _____
<input type="checkbox"/> Speech _____	<input type="checkbox"/> Educational _____	<input type="checkbox"/> Other _____

To the best of my knowledge the information contained above is accurate.

Parent initial _____ Staff initial _____ Date _____

Medical Information (continued)

Child's name	Birth date
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Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone
Physician's practice address	City	State Zip
Preferred hospital/clinic for emergency care	City	State
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State Zip

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number
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Child's Immunization History (please attach a copy of your child's immunization records)

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state.

Anthrax	Influenza	Pneumococcal disease	Smallpox
Diphtheria	Lyme Disease	Polio	Tetanus
Haemophilus Influenzae type b (Hib)	Measles	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	Mumps	Rubella	Varicella (Chickenpox)
Human Papillomavirus (HPV)	Pertussis (Whooping Cough)	Shingles (Herpes Zoster)	Yellow Fever

Additional Medical Policies

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations. **Initial** _____
2. I agree to provide information to the child care center about my child's Covid-19 negative status and/or vaccination status, medical conditions, illnesses, allergies or other needs. _____
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious. _____
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*. _____

Emergency Medical Authorization & Consent

In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician. **Initial** _____

In case of a medical emergency, I agree that my child may receive first aid and/or CPR. _____

In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel. _____

In case of a medical emergency, I will be responsible for the emergency medical expenses. _____

In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. _____

I give my permission to this center to apply sunscreen and insect repellent to my child. *Please check which product you will permit.* **Initial** _____

I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name. _____

I have special instructions for the application process. None _____

Parent initial _____ Staff initial _____ Date _____

Rate Agreement and Contract

Child's name _____	Birth date _____
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Hours of Operation

Regular operating hours are **Monday through Friday 7:00 AM to 6:00 PM** except closings for various holidays, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on **WSB Channel 2**. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for child care are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

I would prefer to make tuition payments on a weekly bi-weekly monthly **basis.**

Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

- Starting on _____ a fee of \$ _____ is due <input type="checkbox"/> weekly. <input type="checkbox"/> bi-weekly. <input type="checkbox"/> monthly.	Initial
- Tuition is due and payable on the <input type="checkbox"/> first business day of the week. <input type="checkbox"/> the 1 st and 15 th of the month or next business day. <input type="checkbox"/> first business day of the month.	_____
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization, contagious illness, or absence at the request of a doctor (a written doctor's note is required to receive credit).	_____
- I agree to pay the full tuition in advance of services rendered.	_____
- I agree to pay the full tuition fee even if my child is absent for one or more days.	_____
- A late fee of \$15 is due if tuition is not received on time.	_____
- A non-refundable registration fee of \$50 is due upon registration.	_____
- A late pick-up fee of \$25 is due if my child is not picked up before closing.	_____
- Accounts two weeks in arrears may result in immediate termination of service.	_____
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required.	_____
- All returned checks or ACH transactions (automatic debits) will be charged a fee up to the maximum amount allowed by law. Two or more returned checks or ACH transactions will result in my account being place on "money order only" status.	_____
- A receipt for income tax purposes <input type="checkbox"/> will be provided by January 31 st .	_____

Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Initial

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Initial

Parent initial _____ Staff initial _____ Date _____

Other Agreements (continued)

Child's name	Birth date
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Walking Excursions

I give my permission for my child to participate in supervised walking excursions near and around the center. _____ **Initial**

Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them. _____ **Initial**

I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement. _____

Information contained in the **Family Handbook** may be subject to change. _____

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement* and the *Family Handbook*.

 Primary Parent/Guardian/Sponsor Signature Date Center Staff Signature Date