SCOTTDALE CHILD DEVELOPMENT & FAMILY RESOURCE CENTER, INC.
479 Warren Ave/ P.O. Box 904 ~ Scottdale, Georgia 30079 ~ Phone (404) 294-8362 Fax (404) 294-5809
Email: info@scottdale.org Website: www.scottdale.org

ENROLLMENT APPLICATION

Type of Service Requesting: ☐ Infants ☐ Toddler I ☐ Toddler II ☐ 3 Year Olds ☐ Pre-K ☐ Pre-K Extended Care ☐ Part-Time Care

Entrance Date: _____ **Withdrawal Date:** _____

***CHILD'S* Name:** _____
Last **First** **Middle**

Address: _____ **Date of Birth:** MM - DD - YYYY

_____ **Age:** _____ ☐ Years ☐ Months

City/State/Zip: _____ **Gender:** ☐ Female ☐ Male

County: ☐ DeKalb ☐ Gwinnett ☐ Fulton
☐ Clayton ☐ Rockdale ☐ Other: _____

Social Security Number: ☐☐☐~☐☐~☐☐☐☐

***MOTHER'S* Name:** _____
Last **First** **Middle**

Address: _____ **Home Telephone:** _____

If Different: _____ **Cell:** _____ **Work** _____

City/State/Zip: _____ **Employer:** _____

County: ☐ DeKalb ☐ Gwinnett ☐ Fulton
☐ Clayton ☐ Rockdale ☐ Other: _____

Work Address: _____

City/State/Zip: _____

Head of Household: ☐ Yes ☐ No **Email Address:** _____

***FATHER'S* Name:** _____
Last **First** **Middle**

Address: _____ **Home Telephone:** _____

If Different: _____ **Cell:** _____ **Work** _____

City/State/Zip: _____ **Employer:** _____

County: ☐ DeKalb ☐ Gwinnett ☐ Fulton
☐ Clayton ☐ Rockdale ☐ Other: _____

Work Address: _____

City/State/Zip: _____

Head of Household: ☐ Yes ☐ No **Email Address:** _____

1st Emergency Contact Person

Emergency Contact (Person to contact in the event that either Parent/Guardian cannot be reached. Individual must also be on the authorized pickup list):

NAME
Last: First: Middle:

Home Phone: ( )-_____ Work Phone: ( )-_____ Cell/Other: ( )-_____

Employer: _____

Relationship to Child: _____ Relationship to Parent: _____

2nd Emergency Contact Person

Emergency Contact (Person to contact in the event that either Parent/Guardian cannot be reached. Individual must also be on the authorized pickup list):

NAME
Last: First: Middle:

Home Phone: ( )-_____ Work Phone: ( )-_____ Cell/Other: ( )-_____

Employer: _____

Relationship to Child: _____ Relationship to Parent: _____

3rd Emergency Contact Person

Emergency Contact (Person to contact in the event that either Parent/Guardian cannot be reached. Individual must also be on the authorized pickup list):

NAME
Last: First: Middle:

Home Phone: ( )-_____ Work Phone: ( )-_____ Cell/Other: ( )-_____

Employer: _____

Relationship to Child: _____ Relationship to Parent: _____

Medical Details

Child's Primary Medical Center: _____

Child's Physician: _____ Physician's Contact Number: ( ) _____ Ext.____

Address: _____ City/State/Zip: _____

My child has the following special need(s):

NONE ☐

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at this center:

NONE ☐

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing allergies, illness, or health concerns:

NONE ☐

_____

_____

Medical Release

I hereby give my permission to Scottdale Child Development & Family Resource Center, Inc. (the Center) staff to seek medical treatment (private physician or hospital) or surgical care for my child should an emergency arises. I authorize the Center to take whatever emergency medical services for transportation to a hospital or clinic. It is understood that a conscientious effort will be made to locate Parent/Guardian before any action is taken. In the event that I, the Parent/Guardian, or the emergency contacts cannot be reached, I fully understand, agree, and relinquish all liability against the Center for any actions taken on behalf of the welfare of my child.

General Release

I verify all of the above information to be **CORRECT** and **TRUE** to the best of my knowledge.

Signature of Parent/Guardian: _____ Date: _____

Review Date: _____

_____

_____

_____

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ENROLLEE AUTHORIZED PICKUP FORM

Due to the rapid change in the information listed below, we ask that you consistently update any changes in children's addresses, phone numbers, parent cell or work numbers, and that of the emergency contact person. It is important that we have correct information to reach you in the event of illness or accident involving your child.

***CHILD'S* Name:** _____
Last First Middle

Address: _____

City/State/County/Zip: _____

***MOTHER'S* Name:** _____

Address If Different: _____

City/State/County/Zip: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

***FATHER'S* Name:** _____

Address If Different: _____

City/State/County/Zip: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

***EMERGENCY CONTACT PERSON*:** _____

Address If Different: _____

City/State/County/Zip: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Relationship to Child: _____ **Relationship to Parent:** _____

******Please notify designated pickup person that they will have to present a Photo ID, so we can copy for our files.**

Scottdale
Child Development and Family Resource Center of Central DeKalb

Date: ____________________

Authorization For Pickup:

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

Name: ______________________ Phone #: ______________ Date: ___/___/___
Relationship to Child: ______________ Relationship to Parent: ______________

******Please notify designated pickup person that they will have to present a Photo ID, so we can copy for our files.**

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CENTER ENROLLMENT AGREEMENT

Name of Child: _____

Name of Parent: _____ **Date:** _____

Scottdale Child Development Center agrees to:

- Provide a high quality child development and family supportive program Monday through Friday at the Center's published rates, according to the classroom in which the child is placed. For the schedule of Holidays, Non-Pre-K Days, and Center Closings, please see the Parent Handbook.

- Keep me informed of any incident, including illness, injuries, adverse reaction to medications, and services provided at the center which include my child.

- Obtain written authorization from me before my child participates in field trips, and special activities away from the center; and water related activities occurring in water that is more than two (2) FEET DEEP. [*In the event of an emergency such as fire, severe weather, power failure, loss of utilities, gas leak, bomb threat or structural damage, the children will be transported by designated safe vehicles or by walking (dependant upon the nature of the emergency) to Hamilton Community Center at 3262 Glendale Road, Scottdale (404)508-7562. Parents or authorized adults will be called by a member of the Center staff to pick up their child(ren) if necessary. A member of the Center staff will notify the proper authorities and the Center Director as soon as possible.

_____Yes_____No
I have received a copy of the Parent Handbook and understand that I am expected to follow the policies and procedures as outlined as well as any amendments.

_____Yes_____No
I understand SCDC provides breakfast, lunch, and an afternoon snack that meets the guidelines of the Child and Adult Care Food Program. Extra food or food substitutes for medical, personal, or religious reasons must be submitted in writing to the center director.

_____Yes_____No
I understand that NO medication can be administered unless the Medicine Authorization form is filled out completely. ALL medicine must be in its original container that is child-proof and labeled with the following information: Child's first and last name clearly marked. Name of the health professional that prescribed or

recommended the medication, date prescription was filled; expiration dated, specific instructions for giving, storing, and disposing of medication, and be in a child-proof container. Authorization for medicine is for one week only. A new form must be submitted every Monday.

_____Yes_____No

I understand my child must be escorted into and from the classroom by a parent or an authorized adult.

_____Yes_____No

I understand it is my responsibility to keep my child's records current to reflect any significant changes as they occur such as: address, phone numbers, work location, emergency contacts, child's physician, child's health insurance, health status, infant feeding plans, immunization certificate, health check, (Ear, Eye, & Dental Exam-Pre-K)

_____Yes_____No

I understand that at least twice each year I will be expected to meet with my child's teacher for a parent/teacher conference to be scheduled at a designated time.

_____Yes_____No

I understand I am expected to attend at least two parent meetings/activities per year.

_____Yes_____No

I understand that the daily classroom routine includes outside time twice per day as required by licensing. Children in attendance must be well enough to go outside so that the staff can maintain adequate staff/child ratios.

_____Yes_____No

I give my permission for my child to be photographed or videotaped in connection with publicity or SCDC; provided, however, that she/he not be identified by last name unless expressly authorized by parent or guardian.

_____Yes_____No

I give my permission for my child to be developmentally assessed using the High Scope COR Assessment. I understand that results are used to plan appropriate learning experiences to help my child reach his/her developmental milestones. I will be informed about the results. In the event further assessment is needed I will be notified.

_____Yes_____No

I give my permission for my child to be screened using the Brigance Screening, Ages and Stages Questionnaire, and Child Observation Record to assure that no child who may be at risk is overlooked. It will also assist the teachers in determining how to best help the children meet his/her developmental milestones.

_____Yes_____No

I understand SCDC may schedule community service to perform sensory and health screens at the center. I will be informed at the time of the screen and will be informed about the results.

☐ Lead **☐ Vision** **☐ Hearing** **☐ Dental**

☐ Speech/Language **☐ Behavioral** **☐ Height/Weight**

_____Yes_____No
I understand that the staff is required by law to report any suspicions of child abuse or neglect to the proper authorities.

_____Yes_____No
I agree to participate in conferences with SCDC staff strategize about ways to best help my child meet his/her developmental milestones and to prepare him/her to be ready for school. I agree to follow up with health care and community resources in a timely fashion to best help my child meet his/her developmental milestones and to prepare him/her to be ready for school.

_____Yes_____No
I understand that the names of children with allergies, program restrictions, or special circumstances will be discreetly posted in the child's classroom and in the kitchen for easy access by all adults working with the child.

_____Yes_____No_____N/A
I understand that Pre-K children must be present by 8:30 a.m. or they will be tardy...tardiness is cause for dismissal from Pre-K.

_____Yes_____No_____N/A
I understand my child should attend everyday and that I should call the center on the days he/she will be absent.(Pre-K only)

_____Yes_____No
I understand that information pertaining children enrolled at SCDC is considered confidential and may not be released by center staff without first obtaining written permission signed by parents except in the following situations:

- Relevant information relating to the children's family situations, medical status and behavioral characteristics on the children enrolled at the center at any time shall be shared by center staff among teachers in the Center, with members of the child care licensing body - Georgia Bright from the Start Department of Early Care and Learning or with other persons authorized by these rules or the law to receive such information, or with other persons in an emergency situation involving the child. Monitors from funding, licensing and accrediting entities may review files to determine compliance by access to a child's file is limited in order to protect the privacy of you and your child.

Parent Signature: _____ **Date:**_____

Signature of Authorized Representative of the Center: _____

Date: _____

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PHOTOGRAPH/VIDEOTAPE RELEASE

I, _____ hereby **GRANT PERMISSION** for the provider listed on the Registration Form, and certain agencies or entries contracted by the provider which shall include, but not be limited to, the Department of Early Care and Learning ("DECAL"), the Department of Education and colleges/ universities, to record the participation and appearance of my child(ren) _____, by photograph and/ or videotape in connection with daily activities for the purposes of news releases, reporting and assessing the progress of children and the program.

DECAL is authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purposes that DECAL deems appropriate. Such photograph(s) and/or videotape may appear in printed or visual materials for DECAL and/or DECAL's web-site.

The undersigned hereby jointly and severally releases, acquits, forgives and discharges the provider, DECAL, and other entities contracted by the provider, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

OR

I, _____, **DENY** authorization of having my child(ren), _____, photograph and/or videotaped unless I submit a written authorization to do so.

Signature (Parent/ Guardian): _____

Date: _____

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VEHICLE EMERGENCY MEDICAL INFORMATION

CHILD'S Name: _____ Date of Birth ____/____/____ Age____ Sex___ SSN#_____
Last First Middle

Address: _____ City/State/County/Zip: _____

Emergency Contacts:

Parent/Guardian (Mother) _____ Home Phone _____ Work Phone_____ Cell Phone_____

Parent/Guardian (Father) _____ Home Phone _____ Work Phone_____ Cell Phone_____

Emergency Contact Person _____ Home Phone _____ Work Phone_____ Cell Phone_____

MEDICAL INFORMATION:

Is your child presently taking any medications? ( ) Yes ( ) No Type and frequency: _____

Is your child allergic to any medications? ( ) Yes ( ) No Explain: _____

Does your child have any dietary restrictions or allergies? ( ) Yes ( ) No Explain: _____

Are there any health concerns, special medical needs or conditions we should know about? ( ) Yes ( ) No
Explain: _____

Clinic/Physician's Name: _____ Address: _____

_____

Phone # _____ Insurance/Medical ID#: _____

Medical release: I hereby give my permission to Scottdale Child Development & Family Resource Center, Inc. (the Center) staff to seek medical treatment (private physician or hospital) or surgical cares for my child should an emergency arise. I authorize the Center to take whatever emergency medical services for transportation to a hospital or clinic. It is understood that a conscientious effort will be made to locate Parent/Guardian before any action is taken. In the event that I, the Parent/Guardian, or the emergency contacts cannot be reached, I fully understand, agree, and relinquish all liability against the Center for any actions taken on behalf of the welfare of my child.

Parent/Guardian Signature _____ Date_____