DISCOVERY ZONE KIDS

703 William Smith Blvd.
Evans, Ga 30809
(706) 496-2489

CHILD INFORMATION

NAME: _____

SEX: **M / F** AGE: _____ DATE OF BIRTH: _____ HOME PHONE _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

PARENT INFORMATION

PARENT 1: _____

ADDRESS (IF DIFFERENT FROM CHILD): _____

PHONE: _____ EMAIL: _____

EMPLOYER: _____ WORK PHONE: _____

PARENT 2: _____

ADDRESS (IF DIFFERENT FROM CHILD): _____

PHONE: _____ EMAIL: _____

EMPLOYER: _____ WORK PHONE: _____

CHILD'S LIVING ARRANGEMENTS: (CHECK ONE) □ BOTH PARENTS □ MOTHER □ FATHER □ OTHER

CHILD'S LEGAL GUARDIAN: (CHECK ONE) □ BOTH PARENTS □ MOTHER □ FATHER □ OTHER

AUTHORIZED PICK-UPS & EMERGENCY CONTACTS

THE FOLLOWING PEOPLE SHOULD BE CONTACTED IF PARENT/GUARDIAN CANNOT BE REACHED. THE CHILD MAY ALSO BE RELEASED TO THE FOLLOWING:

1. NAME: _____

   RELATIONSHIP TO CHILD: _____ RELATIONSHIP TO PARENT: _____

   PHONE: _____ ADDRESS: _____

2. NAME: _____

   RELATIONSHIP TO CHILD: _____ RELATIONSHIP TO PARENT: _____

   PHONE: _____ ADDRESS: _____

3. NAME: _____

   RELATIONSHIP TO CHILD: _____ RELATIONSHIP TO PARENT: _____

   PHONE: _____ ADDRESS: _____

SCHOOL INFORMATION

NAME OF PUBLIC/PRIVATE SCHOOL CHILD ATTENDS (IF ANY):

□ EVANS ELEMENTARY GRADE: _____ □ BAKER PLACE ELEMENTARY GRADE: _____

□ LEWISTON ELEMENTARY GRADE: _____ □ OTHER: _____

MEDICAL INFORMATION

CHILD'S DOCTOR: _____ CLINIC'S NAME: _____

PHONE NUMBER: _____ ADDRESS: _____

MY CHILD HAS THE FOLLOWING **SPECIAL NEEDS**: _____

_____

THE FOLLOWING S**PECIAL 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 PREEXISTING ILLNESS, ALLERGIES, OR HEALTH CONCERNS: _____

_____

EMERGENCY MEDICAL AUTHORIZATION

SHOULD (CHILD'S NAME) _____ DATE OF BIRTH _____ SUFFERS AN INJURY OR ILLNESS WHILE IN THE CARE OF DISCOVERY ZONE KIDS 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 NAME (PRINT): _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FACILITY ADMINISTRATOR/PERSON-IN-CHARGE (PRINT): _____

FACILITY ADMINISTRATOR/PERSON-IN-CHARGE SIGNATURE _____

DATE RECEIVED _____

PARENTAL AGREEMENT WITH DISCOVERY ZONE KIDS

DISCOVERY ZONE KIDS AGREES TO PROVIDE CHILD CARE FOR (CHILD'S NAME) _____

ON THE FOLLOWING DAYS OF THE WEEK (CIRCLE APPLICABLE DAYS) MONDAY, TUESDAY, WEDNESDAY, THURSDAY, AND FRIDAY FROM

_____AM TO _____ PM BEGINNING THE MONTH OF _____AND ENDING THE MONTH

OF _____.

MY CHILD WILL PARTICIPATE IN THE FOLLOWING MEAL PLAN (CIRCLE APPLICABLE MEALS AND SNACKS):

BREAKFAST LUNCH AFTERNOON SNACK EVENING 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), DOSAGE, 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 (I.E. – TELEPHONE NUMBER, WORK LOCATION, EMERGENCY CONTACTS, CHILD'S PHYSICIAN, CHILD'S HEALTH STATUS, INFANT FEEDING PLANS, IMMUNIZATION RECORDS, ETC.).

THE FACILITY AGREES TO KEEP ME INFORMED OF ANY INCIDENTS, INCLUDING ILLNESSES, INJURIES, ADVERSE REACTIONS TO MEDICATIONS, ETC. WHICH INCLUDES MY CHILD.

THE FACILITY DIRECTOR 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 CHILD CARE 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 POLICY AND PROCEDURES FOR DISCOVERY ZONE KIDS.

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 NEEDS. I ALSO UNDERSTAND THAT MY PARTICIPATION IS ENCOURAGED IN FACILITY ACTIVITIES.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

FACILITY ADMINISTRATOR SIGNATURE _____ DATE _____

OFFICE USE ONLY:

ENTRANCE DATE_____ **WITHDRAWAL DATE**_____