



P.O. Box 243 - Tifton, Georgia - 31793 Phone: (229) 382-9919 Fax: (229) 382-3749

Child's First Name: _____ Child's Last Name: _____ Middle Initial: ____
Sex: M ___ F ___ Date of Birth: _____ School: _____ HR Teacher: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Parent(s) or Guardian(s) with whom the child resides: _____
Circle Days child will attend: M T W R F from 3:15 until _____. Grade _____
Other Children in KAC: _____ School: _____

Mother's Name: _____ Home Phone: (____) _____
Home Address: (If Different) _____ City: _____ State: _____ Zip: _____
Cell Phone or Beeper: (____) _____ Place of Employment: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Work Phone: (____) _____ E-mail Address: _____

Father's Name: _____ Home Phone: (____) _____
Home Address: (If Different) _____ City: _____ State: _____ Zip: _____
Cell Phone or Beeper: (____) _____ Place of Employment: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Work Phone: (____) _____ E-mail Address: _____

***Regular departure procedures:**

Picked up by: (First and Last Name) _____

Relationship to Child: _____

Address: _____ City: _____ State: _____ Zip: _____

*** Other Persons Authorized to Pick Up my Child:**

1. Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

3. Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

Medical Care and Emergency Contact Information

Emergency Contacts:

Name: _____ Phone (____) _____

Name: _____ Phone (____) _____

Name: _____ Phone (____) _____

Child's Physician: _____ Phone (____) _____

Family Physician: _____ Phone (____) _____

Known allergies of child: _____

Nutritional snacks will be provided daily to children as part of the program. Does your child have any dietary restrictions? _____ If yes, explain _____

Describe past serious illnesses or hospitalization, with dates: _____

Medicines taken by child: _____

Describe all physical conditions or illnesses which could affect the child's participation in the program or proper medical treatment (epilepsy, diabetes, poor blood clotting, etc.) _____

Health Insurance Company: _____

I give permission for the KAC staff to administer Tylenol to my child when needed. _____
(initials)

Emergency Medical Treatment Consent

I hereby give Kids' Advocacy Coalition (KAC) permission to provide first aid care for my child, _____ . In the event I cannot be reached, I hereby authorize KAC to call 911 and transport my child to the emergency room of the hospital listed below, and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). I agree to accept financial responsibility for all medical expenses incurred.

Hospital: _____

*Parent/Guardian Date

*Parent/Guardian Date

*Both custodial parents must sign this form.

Parental Agreements With Child Care Facility

1. The Kids' Advocacy Coalition agrees to provide day care for _____
(Child's name)
On _____, _____ pm to _____ pm from _____ to _____.
(days of the week) (time) (time) (month) (month)
My child can or cannot participate in the afternoon snack. (Circle one) can cannot
2. I understand I am responsible for a \$40 registration fee for each child. I understand that I am responsible for weekly payments of \$30 for 3:15 – 4:45 care or \$40 for 3:15 – 6:00 care, paid in advance, or \$6/\$8 per day when school is in session for only part of the week. I will give two weeks notice of withdrawal from the program. If notice is not given, I will pay for an additional two weeks. If I can not meet this contract, I will contact the KAC director at 382-9919.
3. I understand and agree that if I become more than two weeks behind in fee payments, I will be required to make other arrangements for after school care for my child.
4. In the event of illness, vacation, or other absences such as music lessons or doctor's appointments, the staff will be notified, and I am responsible for my child. Communication with the after school staff can be made through the KAC office at 382-9919 or email at rcamarillo@kac-ccrr.org.
5. If my child becomes a discipline problem while in the after school program, a conference will be arranged between myself and the staff.
6. I agree to adhere to the after school care and enrichment program policies and give my child permission to participate fully in the program.
7. I give permission for my child to appear in any media coverage approved by the after school program. I understand that the director in conjunction with Kids' Advocacy Coalition will determine the appropriate requests.
8. I agree to pick up my child by 6:00 pm. I understand that a late fee of \$5.00 will be charged for students picked up from 6:01 pm – 6:15 pm, with an additional \$10 for increments of 15 minutes. Parents who are late three times per month will be asked to make other arrangements for after school care.
9. The after school child care staff will assume full responsibility for my child from check in time until he/she leaves. The child must check in with the staff and must be signed out daily when he/she is picked up. My child will not be allowed to enter or leave the facility without being escorted by the parent, person authorized by parent, or facility personnel.
10. I acknowledge it is my responsibility to keep my child's records current and report any significant changes as they occur, e.g. telephone numbers, work location, emergency contacts, child's physician, child's health status and immunization records, etc.

11. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable diseases, which include my child.
12. A copy of each child's immunization record will be given to the lead teacher. No child shall continue enrollment in the center for more than thirty (30) days without such evidence.
13. 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.
14. I understand that it is my responsibility to provide insurance coverage for my child.
15. The Kids' Advocacy Coalition 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.
16. The after school child care program is designed to be a flexible program which provides safe and appropriate care for a group of elementary school students of varying ages and abilities while the parents are at work or in school. If, after a trial period, the program is unable to successfully meet the needs of any child, it may be deemed necessary for the child to be cared for in a setting which is appropriate for his/her needs. This decision will only be made after considering input from the parents, the staff, and/or any specialist whose expertise would be beneficial.
17. I have received a copy and agree to abide by the policies and procedures for Kids' Advocacy Coalition.

The following information is voluntary and will be used for seeking grant funds for Kids' Advocacy Coalition. All information will be kept confidential.

Race _____

Is your child served by an IEP or 504 Plan? YES NO

Signature (Custodial Parent/Guardian) _____ Date _____

Signature (Lead Teacher) _____ Date _____