Compass Academy
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Enrollment Agreement /Terms and Conditions

Entrance Date_____ Withdrawal Date _____
Child's Name_____Sex_____Age_____Date of birth_____
Home Address (Street)_____
City_____State_____Zip_____

Mother's Name_____
Home Phone Number_____Cell Number:_____
Mother's Home Address (if different from child's) Street_____
City_____State_____Zip_____
Mother's Occupation _____Mother's Birthday _____
Mother's Place of Employment_____Work Phone #_____
Employer's Street Address_____City_____State_____Zip_____
Email: _____

Father's Name_____
Home Phone Number_____Cell Number_____
Father's Home Address (if different from child's) Street_____
City_____State_____Zip_____
Father's Occupation _____Father's Birthday _____
Father's Place of Employment _____Work Phone _____
Employer's Street Address_____City_____State_____Zip_____
Email: _____

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_____
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____Address_____
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

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

Name_____Telephone Number_____
Name_____Telephone Number_____
Name_____Telephone Number_____

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:_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____ Date of birth_____
Suffer an injury or illness while in the care of Compass Academy 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.

Does your child have Health Insurance? Yes ( ) or No ( ), If yes please provide the following:
Name of the Insurance provider: _____
Policy Number _____ Group Number _____

If there is no health insurance for the child, I (We) shall assume responsibility for payment for services.

Parent/Guardian:_____
Name Signature Date

Facility Administrator/Person-In-Charge_____
Name Signature

Date:_____

2820 Cobb Lane, Smyrna GA 30082
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Parental Agreements with Child Care Facility

_____agrees to provide day care for
(Name of facility)
_____ 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

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

The _____ 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 policies and procedures for Compass Academy.

I understand that the center 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.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

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ACKNOWLEDGEMENT FORM

- ***I have read the holiday schedule and closing stated in the enrollment package of Compass Academy.***
- ***I have read and agreed to abide by the policies and procedures of compass academy stated in the Compass Academy parent handbook.***
- ***I understand it's my responsibility to provide an updated copy of my child's Immunization Records as its mandatory (my child can be sent home if it's not provided) and keep all documents and information current.***
- ***I will provide a four-week written notice of withdrawal. If the notice of four weeks is not provided, I agree to pay the fees for four weeks, whether or not my child attends.***
- ***If you decide to keep your child home, for any reason (sick or social), you will still be obliged to pay the tuition in full for that period of absence.***
- ***Compass Academy reserves the right to refuse admission.***

Child's Name:_____

Parent/Guardian Name: _____

Parent/Guardian signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian signature: _____

Date: _____

Owner/Director Name: _____

Owner /Director Signature: _____

Date: _____

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CHILD'S SCHEDULE AND INTERESTS

The following information will assist the provider to understand and care for your child. Please describe your child's eating habits, i.e. food likes and dislikes, etc. NOTE: Complete **INFANT FEEDING PLAN** (next page) for children who are under 1 year of age.
Describe the play activities that your child likes, both indoors and out-of-doors.
Describe your child's naptime habits.
Describe your child's toilet and hygiene habits.
Please add any other special information that is important to your child's care here:
Does your child have any known allergies? □ Yes □ No If yes, please explain:
Does your child have any known medical problems? □ Yes □ No If yes, please explain:
Parent/Guardian Name **Signature**
Date:

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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: _____
Amount: _____ Date: _____
Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula) _____

FORMULA/ BREAST MILK			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:**_____

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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 Name: _____

Parent/Guardian signature: _____

Date: _____

*center should maintain in child's file

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Parents or Guardian's
Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, _____, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____

Parents or Guardian's Signatures **Date**

_____ _____

Parent or Guardian (Print Names) **Date**

_____ _____

Center Director's Signature **Date**

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Holiday Schedule/ Supply List

Compass Academy will be closed on the following days. However, tuition is still due for these holidays.

- **Martin Luther King Jr. (Staff Training)**
- **Presidents Day**
- **Memorial Day**
- **Fourth of July (one additional day before or after)**
- **Labor Day**
- **Columbus Day (Staff Training)**
- **Thanksgiving (Wednesday to Friday)**
- **Holiday /Christmas Break**

If any holiday falls on a weekend, we will close on Friday or Monday in that case.

Supply List

All supplies must be labeled with your child's name. You will need to provide the following things to be left here:

**3 complete change of clothing. Soiled clothing will be sent home and a new change of clothes will need to be brought back the next day. No drawstrings on any clothing allowed. Shoes with no laces please. Proper outerwear for outside play

**1 Blanket and 1 Sheet (fitted for mat), Bring it in on Monday and they will be returned every Friday.

**Infants no Blanket but may need couple fitted sheets that fit pack n play or compact crib.

** 2 Sippy cups Labeled

**Pacifier (if your child use uses any)

** Diaper rash cream

**Bibs (soiled bibs sent back daily)

**Diapers or pull-ups: send us a couple weeks supply. We will notify you when the supply is low.

**3 refill packets of baby wipes monthly. Please provide that at the beginning of every month.

Please remember to label your Child's name and last name on all his belongings including jackets and shoes.

No Diaper bags allowed. Only food/milk bags allowed daily. Please empty your bag in your respected tray in the fridge in the lobby.

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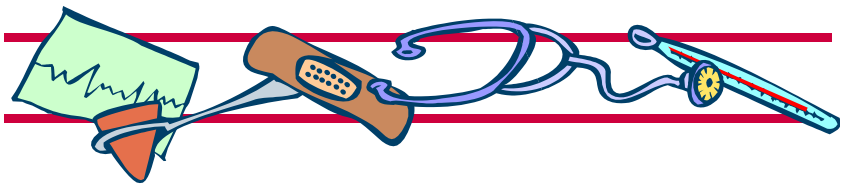
Sick Policy

- **Fever of 100 degrees or greater**. The child may return when fever-free for 24 hours without the use of a fever-reducer.
- **Uncontrolled diarrhea** (defined as an increase in the number of stools, compared with childs normal pattern; increased stool water; or decreased form that is not contained by the diaper or use of the toilet). The child may return when the condition improves (stools are no longer watery and are returning to normal consistency) and is tolerating bland foods or 1/2 strength formula.
- **Vomiting.** The child may return if there has been no vomiting for 24 hours and is tolerating bland foods or 1/2 strength formula.
- **Mouth sores**. A child who has mouth sores and is drooling will be excluded. The child may return when all sores are scabbed and healed.
- **Cold sores.** Child may return once the cold sore has dried up.
- If your child is experiencing itchy, watery eyes (often symptoms of pink eye), please keep your child home until the condition has been evaluated and treatment has begun.
- **Eye infection (Conjunctivitis).** The child may return after 24 hours of antibiotic therapy.
- **Unexplained skin rashes**. If your child is exhibits an unexplained skin rash, please keep your child home until the condition has been evaluated and treated. Child may return once the rash is cleared up or if cleared by a physician.
- **Head lice**. Child may return when hair has been properly treated and all nits have been removed.
- **Severe coughing** (causing them to lose their breath or gag or vomit) not relieved by medication.
- **Colored discharge from the nose**. (Clear Runny nose is ok)
- Any contagious disease or Illnesses.
- **Other illnesses**. Exclusion periods for other illnesses will be noted on the communicable disease notices that are posted.



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