5341 Snapfinger Park Dr
Decatur, Ga 30035
www.EECA.com
EducationElevationCA@gmail.com

ENROLLMENT FORM

____
Entrance Date (mm/dd/yyyy)   Withdrawal Date (mm/dd/yyyy)   Birth date (mm/dd/yyyy)

____
Child's Name (last, first, middle initial)

____
Child's Nickname   Gender   Age

____
Home Address (Street Address, City, State and Zip Code)

(_______)____
Home Telephone Number   Child's Primary Language

____
Name of Public or Private School attending, if any (school age children only)

(_______)____________________________________(_____)__________________________
Mother's Cell Telephone Number   Father's Cell Telephone Number

____(_____)__________________________
Father's Name/Home Address/Telephone Number, if different from child's

____(_____)__________________________
Place of Employment/Address of Employment/Business Number with extension

____(_____)__________________________
Mother's Name/Home Address/Telephone Number, if different from child's

____(_____)__________________________
Place of Employment/Address of Employment/Business Number with extension

Regular Care Arrangements: Lives with [ ] Both Parents [ ] Mother [ ] Father [ ] Other:___________________
Are there any custody arrangements for your child? ___________ If yes, please describe:
____
(A court order with supporting documentation describing custody arrangements and restrictions must be provided.)

____
Child's Legal Guardian(s) [ ] Both Parents [ ] Mother [ ] Father [ ] Other

Transportation arrangement to and from school:
____

©2019 Penn Consulting

The child may be released to the person(s) signing this agreement or to the following:

____
Name Address (Street-City-State-Zip) Telephone Number

____
Relationship to child Relationship to Parent(s) or Guardian
Other identifying information (if any)___________________________________

____
Name Address (Street-City-State-Zip) 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 ____ Phone #(s) ______________________________

Name ____ Phone #(s) ______________________________

Name ____ Phone #(s) ______________________________

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 preexisting illness, allergies, or health concerns:
____

____

____
Are your child's activities restricted by any special needs, developmental disabilities, medical or other conditions? _________ If yes, please describe:

____

____
Medical Insurance Information
Insurance Carrier _____________________ Insured's Name ______________________________________

Primary Care Physician Name ____________________ Telephone (___)_________________________

ID or Policy # ____________________Member Service Number (___)____________________________

©2019 Penn Consulting

EMERGENCY MEDICAL AUTHORIZATION

Should my child suffer an injury or illness while in the care of Education Elevation Children's Academy, Inc. 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 agree to keep the facility informed of changes in telephone numbers, etc. where I/We can be reached. The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child. Permission is granted to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical and transportation expenses incurred.

In consideration of the registration of my child, I release Education Elevation Children's Academy, Inc. and their related companies, directors, officers, employees and agents, from any claims, losses, damages or costs (including attorneys' fees) caused by or arising from my child's registration, use of the facility, or participation in the programs and activities conducted by the program other than to the extent caused by the negligent or willful misconduct of the program and their related companies, directors, officers, employees and agents.

Release and Waiver of Liability for Administering an Asthma Inhaler

Release between Education Elevation Children's Academy, Inc.] and (parent(s)/guardian(s) name) who are the Parent(s)/Guardian(s) of (child's name). (parent(s)/guardian(s) name) have requested Education Elevation Children's Academy, Inc. provide emergency treatment for their child at Education Elevation Children's Academy, Inc. Program and take certain actions described in the child's "Asthma Care Plan" (Authorization), which is attached to this Release and is hereby incorporated by reference.

The parties agree that (parent(s)/guardian(s) name)releases Education Elevation Children's Academy, Inc. and its officers, employees or agents from all liability which may arise as a result of Education Elevation Children's Academy, Inc. administering asthma treatment or following the directions in the Authorization (including any additional physician's instructions or clarifications) as long as such employees or agents exercise reasonable care in taking such actions. (parent(s)/guardian(s) name) also releases Education Elevation Children's Academy, Inc. and its officers, employees or agents from all liability arising out of the use of any materials and/or equipment supplied by the parent(s)/guardian(s) in connection with the asthma treatment as long as such employees or agents exercise reasonable care in the use of such materials or equipment.

This Release shall be governed by the laws of the State of Georgia where Education Elevation Children's Academy, Inc. is located.

Parent Signature(s) ____________________________ Date ______________

FAMILY AGREEMENT

PLEASE CHECK ALL THAT APPLY:
___ The school 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.
___ TRANSPORTATION: I hereby ___ give ___ do not give − consent for my child to be transported and supervised by the operation's employees. ___ for emergency care
___ FIELD TRIPS: I hereby ___ give ___ do not give − my consent for my child to participate in Field Trips:
___ WATER ACTIVITIES: I hereby ___ give ___ do not give − my consent for my child to participate in Water Activities: ___ sprinkler play ___ splashing/wading pools ___ swimming pools water ___ table play
___ VIDEO/PHOTOGRAPHY: I give permission for my child to be photographed and videotaped for use by or on behalf of the facility for educational, training, curriculum, marketing, observation, security, and similar purposes. ___ Yes ___ No
___ DAYS/HOURS: Education Elevation Children's Academy, Inc. agrees to provide educational services for my child
on: (circle all that apply) Monday Tuesday Wednesday Thursday Friday
from ________________a.m. to _____________________p.m..
___ MEALS: The program will provide meals (lunch, morning and afterschool snack) which are in compliance with United States Department of Agriculture guidelines. I agree to provide substitute meals which meet USDA guidelines in the event my child has medical reasons for a substitution and a physician's statement.
___ MEDICATION AUTHORIZATION: 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.
___ AUTHORIZATION TO DISPENSE EXTERNAL PREPARATIONS: I/we authorize Education Elevation Children's Academy, Inc. employees 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) ____
___ SAFETY: 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.
___ RECORDS: 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, and immunization records, etc.
___ INCIDENT REPORTS: The school agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable disease, which include my child.
___ CONFERENCES/PROGRESS REPORTS: I am advised that the school will notify me of

my child's progress, issues relating to his/her care and any individual special needs.
___ PARENT INVOLVEMENT: Education Elevation Children's Academy, Inc. encourages parents to volunteer and attend all functions. I will receive monthly communication regarding these events and opportunities.
___ VOLUNTEER: I volunteer to work ______ hours a week/month with the school.
___ ATTENDANCE: Child's arrival time ______ Child's departure time___________
___ ILLNESS: Notify the staff when my child or any family member has a contagious disease.
___ CARE PLANS/HEALTH ASSESSMENTS: I agree to obtain special care plan(s) and health assessment(s) for my child according to the schedule recommended by the American Academy of Pediatrics or required by state rules and regulations.
___ NO EMPLOYMENT: I will not solicit, employ or enter into any contract with any employee of Education Elevation Children's Academy, Inc. to perform child care or similar services under any circumstances without the express consent of Education Elevation Children's Academy, Inc. If I employ or contract with any employee of Education Elevation Children's Academy, Inc. or person who within one year of the date of such employing or contracting was employed or under contract with Education Elevation Children's Academy, Inc., I will pay the School a placement fee of $5,000.
___ PARENT HANDBOOK: I have received, reviewed and understand the Parent Handbook and related information concerning the school and the educational services provided by Education Elevation Children's Academy, Inc.. I will use the program in accordance with the terms of the Parent Handbook and the policies and procedures made available at the facility. Use of the facility and the services may be denied in the event I do not comply with the terms of this Agreement, or when determined by the administration to be in the best interests of my child or the children enrolled in the afterschool program. The availability of these services are subject to change at any time.
___ REGISTRATION AND PAYMENTS: Registration must be fully completed prior to my child attending the afterschool program. Where applicable, all registration fees and/or tuition fees must be paid in connection with the registration of my child and use of the program.
___ TERMINATION OF ENROLLMENT: If the parent/legal guardian terminates the child's enrollment,
we will suggest an approach to provide a comfortable transition for your child. Refund of payments for services will be limited to policies outlined in the handbook. In the event of noncompliance with the conditions described in the admission agreement and policies that the parent/legal guardian reviewed, accepted, and signed, we will meet with the parent/legal guardian to make a plan for corrective action that specifies the expected action and the period after which termination will occur for continued noncompliance. Program staff members will offer support to the family to achieve compliance and follow the school's grievance procedure. If the corrective action plan is not successful, unless the grievance procedure results in an alternative approach, termination of services will occur. Parent/legal guardian is responsible for fees as outlined in the termination policy (usually equal to one week's tuition).

RECEIPT OF WRITTEN OPERATIONAL POLICIES:
I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

Signature (Parent/Guardian) ________________________________

Date ___________________________

Signature (Parent/Guardian) ________________________________

Date ___________________________

Food Allergy Action Plan

I/we provide consent for my/our child's health care professional to release information and to communicate with my/our child’s teacher/child care provider to discuss information relating to this care plan.

Parent/legal guardian signature ____

Date ________________

Student’s Name:___________________________________**D.O.B:**_____________

ALLERGIC TO:____

STEP 1: TREATMENT

Symptoms: Asthmatic: Yes* No *Higher risk for severe reaction	**Give Checked Medication****: **(To be determined by physician authorizing treatment)
If a food allergen has been ingested, but *no symptoms*:	Epinephrine Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	Epinephrine Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	Epinephrine Antihistamine
Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine Antihistamine
Other† ____	Epinephrine Antihistamine
If reaction is progressing (several of the above areas affected), give:	Epinephrine Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

____

Antihistamine (must be completed for over the counter and prescription medications):
give_______________________________________medication/dose/route ______________________
Other:
give______________________________________ medication/dose/route ______________________
IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

©2019 Penn Consulting

Needed Accommodations (Please describe accommodation and why it is necessary. Attach additional pages if needed to provide complete information.):

Special equipment or medical supplies:

Training needed for staff:

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ____ Phone Number: ________________________
3. Parent____ Phone Number(s) _______________________

4. Emergency contacts:

Name	Relationship	Phone Number(s)

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature____

Date________________________

Doctor's Signature____

Date________________________

Adapted from the Food allergy and Anaphylaxis Network *Food allergy care plan*
www.foodallergy.org

HEALTH CARE PLAN FOR ASTHMA MANAGEMENT

Student: ___________________________________ DOB: ________________ Sex: ______

Parent/Guardian #1: ____

Home phone: _______________ Cell: ______________ Work number: _________________

Parent/Guardian #2: ____

Home phone: _______________ Cell: ______________ Work number: _________________

Emergency Contact: ____
Name Relationship Phone

Health Care Provider: _______________________________________ Phone: ______________

Does the student have allergies? □ No □ Yes

What triggers an asthma episode (check all that apply)

□ Exercise □ Animals □ Pollen □ Mold □ Dust/chalk dust

□ Respiratory infections □ Change in temperature □ Strong odors/fumes

□ Food ____________________________ □ Other ____________________________

Early symptoms of an asthma episode (check all that apply)

□ runny nose □ coughing □ itchy throat

□ sneezing □ wheezing □ tightness in chest

□ irritable □ short of breath □ other
____

Does the student have any activity restrictions? □ No □ Yes, (health care provider note needed)

Has the student been hospitalized for an asthma episode? □ No □ Yes, when: __________

Does the student recognize early symptoms of his/her asthma episodes? □ No □ Yes □ Some

Will a peak flow meter be used during school hours? □ No □ Yes, (authorization needed)

Green Zone – doing well; can participate in usual activities: 80% or more personal best ______

Yellow Zone -- asthma control unstable; having symptoms: 50-79% of best peak flow _______

RED ZONE – Medical Alert; assistance needed, call parents and 911: less than 50% _______

©2019 Penn Consulting

Please list asthma medication(s): □ None □ As needed □ Daily

Name of medication(s)	When/ how many times per day	Oral / Inhaler / Nebulizer

Will asthma medication be needed during school hours? □ No □ Yes, (authorization needed)
Please provide written authorization for all forms. Medication authorization forms must be signed every ten days. Care plans must be updated quarterly or as prescriptions or conditions change. Emergency Plan:

Steps to take during an asthma episode:
1. Check peak flow, if authorized by health care provider.
2. Give medication(s), as authorized by health care provider.
3. If student condition does not improve within 15-20 minutes, notify parent.
4. Seek emergency medical care if the student has any of the following:

✓ Coughs constantly, breathes more than 50 bpm at rest
✓ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
✓ Difficulty breathing with: chest and neck pulled in, stooped body posture, struggling or gasping for air
✓ Trouble walking or talking
✓ Stops playing and cannot start activity again
✓ Lips or fingernails are blue or gray

Other recommendations or accommodations:

The information on this form will be shared with staff who have a need to know.

Parent/Guardian Signature:____ Date:________

Physician Signature: ____ Date: ________

©2019 Penn Consulting

5341 Snapfinger Park Dr
Decatur, Ga 30035
www.EECA.com
EducationElevationCA@gmail.com

Infant/Toddler Feeding and Care Plan

In an attempt to smoothly facilitate your child's transition into our class, please fill out the following form. This information is confidential.

Child's Name ____________________________________ Date _____________

Birthdate_____________________________

Does the child take a 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:

Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used?
____

Amount of formula to be given? ____
Updated amounts of formula? ________________________Date ________________
_______________________ Date ________________
_______________________ Date ________________

Does the child take a pacifier? Yes [ ] No [ ]
When? ____
Food likes __________________________ Food dislikes ___________________________________
Allergies- including any premixed formula
____

Child's Schedule

Breakfast ____
Approximate Time Types and approximate amount of food

Lunch ____
Approximate Time Types and approximate amount of food

Dinner ____
Approximate Time Types and approximate amount of food

Morning Nap __________________________ Afternoon Nap __________________________
Approximate Time Approximate Time

Instructions for the introduction of solid foods ____
____

As needed, please list updated instructions regarding adding new foods or other dietary changes.
____

©2019 Penn Consulting

Has your child experienced any feeding problems? (Please describe in detail) ______________________

____

Is your child: __ breast fed __ bottle fed __ weaned
Supplemental infant information:

Describe your child's present napping pattern ____

____

Does your child usually cry when going to sleep? __ No __ Yes
Does your child cry when waking? __ No __ Yes
Do you have any special ways of helping your child go to sleep?

____

____

Elimination patters (toileting/diapering): ____

Things that comfort or scare your child: ____

Cultural habits/issues that may affect your child's behavior: ____

____

Who will care for your child when he/she is sick:
____

Does your child have any special needs (serious illness, medications, treatments, allergies, food intolerance, conditions, behaviors, etc.? Please describe and have your pediatrician submit a care plan and update it every 90 days.

____

____

____

Has your child had any surgical procedures? __ No __ Yes Describe:

____

What special training, if any, must the staff have to provide care?
____

Please indicate which of the following diseases your child has previously experienced:

__ Whooping Cough __ Pneumonia __ Mumps

__ Chicken Pox __ Measles (10 day) __ Allergies

__ Eczema __ High Temperature (Over 103) __ Neurological

__ Roseola (24 Hr. Measles) __ Rubella (3 day-German Measles) __ Recurrent Ear Infections

Other ____
Please take a moment to tell us anything else that would help us to provide the best care for your child.

____

____