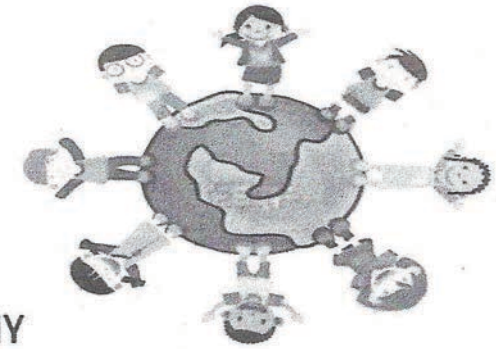

WELCOME TO KIDS R US ACADEMY

PLEASE INITIAL THAT YOU HAVE RECEIVED ALL FORMS OR INFORMATION

___ APPLICATION/ENROLLMENT FORM

___ MEDICAL REPORT

___ IMMUNIZATION HISTORY

___ DISCIPLINE & BEHAVIOR POLICY

___ PERSONAL LIABILITY WAIVER

___ EMERGENCY TRANSPORTATION FORM

___ SHAKEN BABY SYNDROME & ABUSIVE HEAD TRAUMA

___ FOOD PROGRAM

___ SAFE SLEEP POLICY

___ SLEEP POSITION WAVIER **(ONLY FOR 6 MONTHS AND OLDER)**

___ INFANT FEEDING SCHEDULE

___ SUMMARY OF CHILD CARE LAW

CHILD'S NAME: _____

PARENT SIGNATURE: _____ DATE: _____

EMAIL ADDRESS: _____

DIRECTOR SIGNATURE: Nastasha Bennett DATE: _____

CHILDREN'S ENROLLMENT FORM

Entrance Date_____ **Withdrawal Date**_____

Child's Name_____Sex___Age_____Date of birth_____

Home Address (Street)_____

City_____State_____Zip_____

Home Phone Number_____

Father's Name_____Home Phone Number_____

Father's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Father's Place of Employment _____Work Phone _____

Employer's Street Address_____City_____State_____Zip_____

Mother's Name_____Home Phone Number_____

Mother's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Mother's Place of Employment_____Work Phone #_____

Employer's Street Address_____City_____State_____Zip_____

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_____
(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_____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 (Facility name)_____
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:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge Nastasha Bennett
Signature

Date:_____

Parental Acknowledge of Medication Dispense Form:

The following will be required to dispense medication:

Medication must be in original package with name of medication, child's name, dosage, and time/frequency on it.

Emergency Medical Authorization:

I give Kids R US CDC permission to transport my child _____

To Dekalb Medical Center at Hillandale in the case of medical treatment.

Kids R Us agrees to keep me informed of any incidents requiring medical attention involving my child.

Parent/Guardian Signature: _____ Date: _____

Childs Primary Health Care Source:

Pediatrician/Clinic: _____

Phone Number: _____

Address: _____

_____

Any Known Allergies/Pre-Existing Illnesses/Health Concerns/Current Diagnosis being treated:

_____

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses Dekalb Medical at Hillandale

Address 2801 Dekalb Medical Pkwy Lithonia GA 30058

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Kids R Us Academy
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

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 Kids R Us Academy, 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 Signature Date

*center should maintain in child's file

Biting Policy

Biting is unfortunately not unexpected behavior for toddlers. Many toddlers/children communicate through this behavior. However, biting can be harmful to other children and to staff. As a Childcare Center, we understand that biting, unfortunately, is a part of our everyday setting. **We ask parent's to be patient with us as we deal with children who exhibit biting behaviors.** Our goal is to help identify what is causing the biting and try to resolve these issues. **Names of children are not shared with either parent. When Biting Does Occur:** The staff's job is to keep the children safe and help a child that bites learn different, more appropriate behavior. We do not use techniques to alarm, hurt, or frighten children such as biting back or physical punishment

For the child that was bitten:

1. First aid is given to the bite. It is cleaned with soap and water. If the skin is broken, the bite is covered with a bandage and Parents are notified.

For the child that bit:

1. The teacher will express to the child that biting hurts.

2. The child will be placed in quite area with the teacher for no longer than the child's age (one year old, one minute).

3. The parents are notified and "Parent Contact Form" is filled out documenting the incident.

When Biting Continues:

1. The child will be shadowed to help prevent any biting incidents and to determine what is causing the child to bite (teething, communication, frustration, etc.)

3. If a child inflicts 3 bites in a one week period (5 weekdays) in which the skin of another child or staff member is broken or bruised or the bite leaves a significant mark, a conference will be held with the parents to discuss the child's behavior and how the behavior may be modified.

3. If a child bites twice in a 4-hour period, the child will be required to be picked up from day care for the remainder of the day. *****If a child continues to inflict biting the parent's will be asked to make other Childcare arrangements.**

_____ **Date:** _____

Parent Signature

Kids R Us Childcare Agreement:

Child's Name: _____

Date of Enrollment: _____

Childcare Tuition: _____ per week will be paid every Monday. A late fee of $25 will be added if payment is not received by 6:30pm on Tuesday. Children will not be permitted into care on Wednesday if payment is not received.

Hours or care: _____am _____ pm. A late fee of $20 will be charged 5min after the agreed upon time of pickup and $1.00 per min thereafter. This must be paid for the child to return the next day. **Person must be 18 yrs. old to drop off or pick-up child.**

We do not allow any transportation company such as Uber/Lyft to pick up children.

Sick/Absent: Half of tuition will be charged if your child misses a full week due to sickness or absent. **Tuition is based on enrollment not attendance.**

Vacation: Families are given 1-week vacation per year where tuition will not be charged if child is out 5 consecutive days. A 2-week notice is required.

Children must report daily with all supplies needed to carry out the day such as change of clothes, diapers/wipes, bottles, food, etc. All items must be labeled with child's name.

Bottles/Cups must be labeled daily with child's name and current date

I agree to replace any supplies used by Kids R Us in the event my child runs out or does not have any available.

Parent agrees that photos can be taken of child and used for school related activities.

Parent will update center with all contact information, and medical information as needed.

Parent Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PERSONAL LIABILITY AND WAIVER

I understand that field trips and on-site activities may expose my child to some risks and I assume any such risk that may arise there from. I accept full responsibility for all medical expenses for any injuries that might occur to my child by reason of his/her participation.

By signing this form, however, I hereby release Kids R Us Academy administrators, directors, teachers, employees, and volunteers ("released parties") from and against any and all claims, demands, actions, complaints, suits or other forms of liability that any of them may sustain (a) arising out of my child's failure to comply with rules, local, state, and federal laws and District policies, procedures, and the Code of Conduct; (b) arising out of any damage or injury caused by my child; or, (c) arising out of a parent/guardian/or other designated driver's operation of a motor vehicle in relation to this activity. I also agree to indemnify and hold harmless the released parties from the released claims, including any and all related costs, attorney fees, liabilities, settlements, and/or judgments.

SIGNATURE

I confirm that I have carefully read this CONSENT AND RELEASE and agree to its terms knowingly and voluntarily. I also confirm that I am the parent or legal guardian of the child I

I have signed this CONSENT AND RELEASE this ___ day of _____, 20__.

This consent and release has been read and is understood by me.

_____

Child's Name

_____ _____

Signature of Parent or Legal Guardian Date

EMERGENCY INFORMATION

Child's Name: _____

Birthday: _____

Home Address: _____

Home Phone: _____

Father's Name: _____

Mother's Name: _____

Contact Information:

Father: home: _____ work: _____ cell: _____ e-mail: _____

Mother: home: _____ work: _____ cell: _____ e-mail: _____

Alternate Emergency Contact Person(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Medical Information (allergies to medications, foods, other substances, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

Hospital Preference: _____

Child's Doctor: _____ Phone: _____

I agree that the operator may authorize the physician of his/her choice to provide emergency medical care in the event that neither I, my spouse, alternate contact(s), nor my child's doctor can be located immediately.

Parent's Signature: _____ Date: _____

Operator's Signature: Nastashia Bennett Date: _____

Bright from the Start: Georgia Department of Early Care and Learning

Center: Kids R Us

CACFP Meal Benefit Income Eligibility Statement*

F R P

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial) DOB	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? $_____/_____

B. Other Household Members[1]. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Welfare, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of 6 am [am/pm] to 7 pm [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday **Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday ☑ Saturday**

Circle the meals your child will normally receive while in care: **Breakfast ☑ AM Snack ☐ Lunch ☑ PM Snack ☑ Supper ☐ Evening Snack ☐**

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X _____ **Print Name:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: **Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

Total income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility: check (✓) one Free ☐ Reduced ☐ Paid ☐**

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, **there must be at least two signatures on this form: one signature from the Determining Official (the official who** determined initial income classification) and one signature **from the Confirming Official (the official who verified the form's accuracy).**

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

07/2020

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: _____

Infant/Toddler Safe Sleep Policy

Child Care Facility:

KIDS R US CDC

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep related infant deaths. According to N.C. Law, child care providers caring for infants 12 months of age or younger are required to implement a safe sleep policy and share the policy with parents/guardians and staff. We implement the following safe sleep policy.
References: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

Safe Sleep Practices

1. We train all staff, substitutes, and volunteers caring for infants aged 12 months or younger on how to implement our Infant/Toddler Safe Sleep Policy.
2. We always place infants under 6 months of age on their **backs to sleep,** unless a signed *ITS-SIDS Alternate Sleep Position Health Care Professional Waiver* is in the infant's file and posted at the infant's crib. We retain the waiver in the child's record for as long as they are enrolled.
3. ☐ We do not accept *Parent Waivers* for infants older than six months.* **-OR-**
   ☑ We accept the *ITS-SIDS Alternate Sleep Position Parent Waiver.*
4. We place infants on their backs to sleep even after they can easily turn over from the back to the stomach. We then allow them to adopt their own position for sleep.
   ☑ We document when each infant can roll from back to stomach and tell the parents. We put a notice in the child's file and on or near the infant's crib.*
5. We visually check sleeping infants every 15 minutes and record what we see on a *Sleep Chart.*
   ☑ We check infants 2-4 month of age more frequently.*
6. We maintain the temperature in the room where infants sleep between 68-75°F and check it on the thermometer in the room.
   ☑ We further reduce the risk of overheating by not over-dressing infants*
7. We provide all infants supervised "tummy time" daily.
8. We follow N.C Child Care Rules .0901(j) and .1706(g) regarding breastfeeding.
   ☑ We further encourage breastfeeding in the following ways:* Newsletter By CNAP

Safe Sleep Environment

9. We use Consumer Product Safety Commission (CPSC) approved cribs or other approved sleep spaces for infants. Each infant has his or her own crib or sleep space.
10. ☐ We do not allow infants to use pacifiers. **-OR-**
    ☑ We allow pacifiers without any attachments. Pacifiers attached to clothing will be removed when placed to sleep.
    ☑ We do not reinsert the pacifier in the infant's mouth if it falls out.*
    ☐ We remove the pacifier from the crib once it has fallen from the infant's mouth.*
11. We do not allow infants to be swaddled.
12. We do not cover infants' heads with blankets or bedding.
13. We do not allow garments that restrict movement.*
14. We do not allow any objects, such as, pillows, blankets, or toys other than pacifiers in the crib or sleep space.
15. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.
16. We give all parents/guardians of infants a written copy of the *Infant/Toddler Safe Sleep Policy* before enrollment. We review the policy with them, and ask them to sign a statement saying they received and reviewed the policy.
    ☑ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
17. Family child care homes: We post a copy of this policy and a safe sleep practices poster in the infant sleep room where it can easily be read.
18. Centers: We post a copy of this policy in the infant sleep room where it can easily be read.

**Indicates we follow this best practice recommendation.*

Effective date: Jan 2019 **Review date(s):** _____ **Revision date(s):** _____

Distribution: We give parents/guardians a copy of the policy. We give all staff, substitutes and volunteers a copy to review. We inform them of changes 14 days before the effective date. We give parents/guardians a copy of the policy they signed and put a copy in child's file.

I, the undersigned parent/guardian of _____ (child's full name), have received a copy of the facility's *Infant/Toddler Safe Sleep Policy*. I have read the policy and discussed it the facility director/owner/operator, or other designated staff member.

Child's Enrollment Date: _____ Parent/Guardian Signature: _____ Date: _____

Facility Representative Signature: Nevertasha Berries Date: _____

Alternative Sleep Position Waiver

Parent

Parents may only use this waiver for infants over the age of six months.

Parent/guardian completes this section.

Child's name _____ Date of birth _____ Age in months _____

Parent/guardian name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

The child care facility named below places all infants on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome (SIDS); Child Care Rule .0606 (a)(1). As the parent or guardian of the child named above, I request my child be placed to sleep in an alternative sleep position now that my child is 6 months or older; Child Care Rule .0606 (e). The facility shall retain the waiver in the child's record as long as the child is enrolled at the center.
This waiver is valid if I have checked the box(es) below:

☐ I request that my child not be placed on the back to sleep and instead placed to sleep in the alternative sleep position described below.

I request that the child care facility place my child in the alternative sleep position described below.

When placed in crib, child will be placed on back. If childs turn-over on stomach, child can stay in that position.

☐ I request that a wedge is used for my child according to the direction and for the specified reason(s) I provided below :

_____

_____

Effective Dates of Waiver: **from** ____/____/____ **to** ____/____/____

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position described above at my request.

Parent/guardian signature _____ **Date** _____

An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility KIDS R US ACADEMY ID # C.C.L.C.-48928

Facility Representative's Signature Natashia Bennett **Date** _____

YOUTH EDUCATIONAL SERVICES, INC
2321 Main Street, Tucker GA 30084
Phone (770) 938-3188 • Fax (770) 938-6869 • www.yeskidz.com

Infant Affidavit

Name of Sponsor (if applicable) Youth Educational Services, Inc.

Name of Center/Provider _____

Name of Infant: _____

Infant Date of Birth: _____

Name of Parent/Guardian: _____

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: _____
Center/provider will provide the following Iron-fortified infant cereal: _____
Center/provider will provide the following brand of infant foods: _____

****

Parents/Guardians,

Please check one of the following options below and sign this form:

☐ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

☐ I will provide the following meal component to my infant and the center will provide all other meal components:

- ☐ Formula*
- ☐ Cereal
- ☐ Fruit
- ☐ Vegetable
- ☑ Meat/Fish/Poultry/Eggs/Beans/Peas
- ☐ Cheese/Cottage Cheese/Yogurt
- ☐ Bread/Crackers/Breakfast Cereal

7 pm _____ _____
Parent/Guardian Signature Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.