

Authorization for Pick-Up

I hereby authorize GPA to allow my child to leave the facility ONLY with the following person(s):

<input type="radio"/>	_____	_____	_____	_____
	Name	Name	Name	Name
<input type="radio"/>	()	()	()	()
	Phone	Driver's License	Phone	Driver's License
<input type="radio"/>	_____	_____	_____	_____
	Name	Name	Name	Name
<input type="radio"/>	()	()	()	()
	Phone	Driver's License	Phone	Driver's License
<input type="radio"/>	_____	_____	_____	_____
	Parent's/Guardian's Signature	Date		

Additional Authorization

AUTHORIZATION FOR TRANSPORTATION: I hereby ()give ()do not give my consent for my child to be transported and supervised by GPA's staff on field trips and/or to and from school.

<input type="radio"/>	_____	_____
	Parent's/Guardian's Signature	Date
<input type="radio"/>	_____	
	AUTHORIZATION FOR WATER ACTIVITIES: I hereby ()give ()do not give my consent for my child to participate in the following water activities: ()wading pools ()sprinklers ()swimming pools ()other bodies of water provided by the facility	
<input type="radio"/>	_____	_____
	Parent's/Guardian's Signature	Date

Medical Information

<input type="radio"/>	_____		
	Child's Name		
<input type="radio"/>	_____		
	Hospital/Clinic Preference		
<input type="radio"/>	_____	_____	()
	Physician's Name	Address	Phone Number
<input type="radio"/>	_____	_____	()
	Dentist's Name	Address	Phone Number
<input type="radio"/>	_____	_____	_____
	Medical Insurance Carrier	Member's Name	Policy Number
<input type="radio"/>	_____		
	Allergies/special health considerations (please write "none" if none exist)		
<input type="radio"/>	_____		
	Medications taken regularly		
<input type="radio"/>	_____		
	In the event of an emergency, I authorize GPA's personnel to administer first aid or to obtain emergency medical treatment.		
<input type="radio"/>	_____		
	I authorize GPA to consent to any necessary examinations, anesthetics, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the general or specific supervision and on the advice of any physician or surgeon licensed to practice medicine.		
<input type="radio"/>	_____	_____	
	Parent's/Guardian's Signature	Date	

Health Requirements

Child's Name _____

- You must submit your child's most recent immunization records either signed or stamped by the physician's office.

Schedule of Required Immunizations

Vaccine	Birth	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	36 mos	4-6 yrs
Hepatitis B	#1	#2			#3				
Diphtheria, Tetanus, Pertusis (DTP/DTaP)		#1	#2	#3			#4		#5
Haemophilus Influenza type B (Hib)		#1	#2	#3		#4			
Inactivated Polio (IPV)		#1	#2				#3		#4
Measles, Mumps, Rubella (MMR)						#1			#2
Varicella							#1		
Pneumococcal (PCV)		#1	#2	#3		#4			
Hepatitis A								#1	#2

SCHOOL AGE CHILD: My child attends the following school and his/her current immunization record along with a current vision and hearing screening is on file at the school.

- _____ () _____
School Name School Phone School Address

- ADMISSION REQUIREMENT:** One of the following must be presented within one (1) week of your preschool age child's admission to GPA. Please check your indicated option.

() **PHYSICIAN'S STATEMENT:** Statement showing the physician has examined the above named child within the past year and found him/her to be physically able to take part in the GPA program.

() A copy of a medical screening from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, showing no referral for further diagnosis and treatment are indicated.

() A form or written statement from a health service or clinic.

If you do not have any of the above, please check one of the following:

() **PARENT'S STATEMENT:** My child has been examined within the past twelve (12) months by a licensed physician and is able to participate in the GPA program.

Name and Address of Physician or EPSDT Screening Site

() My child has an appointment for a physical examination.

Name and Address of Physician or EPSDT Screening Site

Appointment Date

OR

() I will submit the physician's statement, EPSDT form, health service or clinic form to GPA following the examination.

Parent's/Guardian's Signature

Date

Note: If the medical diagnosis, re-immunization or TB testing conflict with your religious beliefs, you must sign an affidavit to the effect and attach it to this form. If immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate signed by a physician to the effect and attach it to this form.

Vision and Hearing Screening: All children 4 years old by September 1 of the current year are required to submit a copy of a current vision and hearing screening. These screenings are normally conducted in conjunction with the child's annual well exam or you may opt to have the screening performed elsewhere. All screening results are to be turned into the front office by October 1 of the current year.

Parent's/Guardian's Signature

Date

Parent Release for Media Recording

Child's Name _____

Photographs and videos are taken on different occasions such as performances, holidays, outings and special events. We use these pictures and videos in our school for teaching, arts & crafts, albums and various other activities. Our policy allows us to take photos and use your child's image within the school only. We will not use your child's image in publications distributed outside of the school unless you provide "unrestricted usage" authorization.

- Limited usage:** I agree to my child's image used within the GPA setting only (not in the larger community).
- Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by GPA for a variety of purposes, including advertising, and that these images may be used without further notifying me. I do understand that the child's last name will not be used in conjunction with any video or digital images.

Parent's/Guardian's Signature _____

Date _____

Account Agreement

_____	() _____	_____	() _____
Name (last, first)	Home Phone	Employer	Work Phone
_____	() _____	_____	_____
Address	Cell Phone	Address	
_____	_____	_____	_____
City, ST ZIP Code		City, ST ZIP Code	
_____	_____	_____	_____
SSN	Driver's License		
_____	() _____	_____	() _____
Nearest Relative	Phone	Reference	Phone
_____	_____	_____	_____
Address , City, ST ZIP Code		Address, City, ST ZIP Code	

- A registration fee of \$150 per family is due at the time of enrollment. This enrollment fee is not refundable, but is transferrable to another GPA.
- All tuitions and fees are due in advance on the first school day of each week for that week. Tuitions not paid by Tuesday evening will result in a \$5.00 per day late fee until entire balance is paid.
- An annual supply fee is charged on the first day of school in the fall. See the tuition schedule for supply fees.
- A separate summer activity fee will be charged at the beginning of each summer to cover the cost of most activities and events throughout our summer program. See the tuition schedule for summer activity fees.
- A monthly \$12 Stretch-N-Grow fee will be charged for all children in our Older Ones through Pre-K classes.
- Tuition must be paid in full without deduction for absences of any duration or for any cause. There will be no exceptions.
- Parents who pick up their children after the regular closing time (6:30pm) are charged a late fee of \$1.00 per minute for the first five (5) minutes then \$2.00 per minute thereafter.
- A No Call fee of \$10 will be charged to parents failing to inform us of after-school pick up cancellations.
- A \$25 returned check fee will be charged for each returned check. Returned checks will not be submitted for a second collection attempt.
- Two-week's written notice is required upon withdrawal.
- I have received a Parent Handbook containing additional necessary information.
- The customer (parent or guardian) agrees to pay, in the event the account is turned over to an agency or attorney for collection, all reasonable attorney fees plus all attendant collection costs and/or court costs.

The undersigned agrees and understands that the services rendered for child care are subject to the above conditions.

○ Signature _____

Printed Name _____

Date _____

Help Us Get to Know Your Child

Child's Name: _____

Date of Birth: _____

Circle days to attend: **AM** Mon Tues Wed Thurs Fri **Arrival Time** _____ **Departure Time** _____

PM Mon Tues Wed Thurs Fri **Arrival Time** _____ **Departure Time** _____

Meals to attend: Breakfast* AM Snack Lunch PM Snack (*Additional \$1.00 per day charge)

Please list any **special needs** or problems that your child may have, such as: allergies, existing illness, previous serious illness, injuries during the past 12 months, any medications prescribed for long-term continuous use, special dietary requirements and any other information which the staff should be aware of. If none, please specify "none".

Is your child potty trained? Yes No What does your child say when they need to use the potty? _____

Does your child need help () Dressing () Eating () Washing Hands () Tying Shoes

Tell us about your family and help us understand what's important to you as a parent. Give us some insight into your child and let us in on the special relationship you have with him. The more we know about your wants and needs, the richer we can make your child's GPA experience.

What makes your child special?

What activities do you like to share?

Does your child have any special likes or dislikes?

Is this your child's first preschool experience? If so, how often has he/she been away from you or the primary care-giver?

What group size does he/she typically play with?

What are your goals for your child at GPA?

Use five words to describe your child (e.g., happy, serious, affectionate, stubborn, etc.)

What are your child's best and worst times of the day?

What does your child like to do when you first wake up in the morning?

How many siblings does your child have and what are their names/ages?

What does your child like to eat?

What does your child refuse or not like to eat?

What is your child's favorite book?

What is your child's favorite game?

Does your family have any pets? What are they? What are their names?

Parent Handbook Acknowledgement

I have read the GPA Parent Policy and Procedure Handbook, and I understand that I have to follow all aspects of the manual.

CONTENT	INITIALS	CONTENT	INITIALS
ABOUT GPA		ADDED ACTIVITIES	
WELCOME		OUTDOOR PLAY	
MISSION STATEMENT		FIELD TRIPS	
GOALS		WATER ACTIVITIES	
OUR PROGRAMS AND EXPECTATIONS		PARENT INVOLVEMENT	
INFANT AND TODDLERS		BIRTHDAY PARTIES	
PRESCHOOL		SCHOOL PARTIES	
PRE-KINDERGARTEN		ADULT CODE OF CONDUCT	
SCHOOL-AGE		PARENT QUESTIONS	
EXPECTATIONS		HIRING STAFF TO BABYSIT	
ENROLLMENT AND TUITION		ADDITIONAL CONVENIENCES	
ENROLLMENT REQUIREMENTS		LICENSING RULES AND REGULATIONS	
MEDICAL REQUIREMENTS		REPORTING ABUSE/NEGLECT	
HEARING AND VISION SCREENINGS		CHILD CARE LICENSING	
TUITION, FEES AND DISCOUNTS POLICY		LOCAL LICENSE OFFICE	
TAXES		SUMMARY OF PARENT RESPONSIBILITIES	
NON-DISCRIMINATION POLICY		A BEKA BOOK	
OPERATIONAL POLICIES		SCHOOL UNIFORMS	
HOURS OF OPERATION			
HOLIDAYS AND PRE-PLANNED CLOSINGS			
VACATION			
WITHDRAWAL POLICY			
ARRIVAL AND DEPARTURE			
WEATHER AND EMERGENCY CLOSURES			
VISITING OUR CENTER			
CLOTHING AND PERSONAL BELONGINGS			
PHOTO USAGE			
SAFETY AND SECURITY			
EMERGENCY DRILLS			
TRANSPORTATION			
SAFETY PROTOCOL			
CAMERA MONITORING			
HEALTH AND HAPPINESS			
FOOD			
REST PERIOD			
ILLNESS			
MEDICATION			
INJURIES			
BEHAVIOR MANAGEMENT POLICY			
BITING POLICY			

Parent's/Guardian's Signature

Date

Required Medical Releases (to be completed by a healthcare professional)

Child's Name _____

Date of Birth _____

Immunizations

	1 st Dose Date	2 nd Dose Date	3 rd Dose Date	4 th Dose Date	5 th Dose Date	Booster Date
Hepatitis B						
Diphtheria, Tetanus, Pertusis (DTP/DTaP)						
Haemophilus Influenza type B (Hib)						
Inactivated Polio (IPV)						
Measles, Mumps, Rubella (MMR)						
Varicella						
Pneumococcal (PCV)						
Hepatitis A						

VISION AND HEARING SCREENING

VISION

R 20 / _____

L 20 / _____

Pass ____/Fail ____

Signature: Certified Vision Screener _____

Date _____

HEARING

1000 Hz

2000 Hz

4000 Hz

R

--	--	--

Pass ____

L

--	--	--

Fail ____

Signature: Certified Hearing Screener _____

Date _____

***I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.**

Healthcare Professional's Signature _____

Date _____