First Learning Academy

3079 Crystal Avenue • Memphis, Tennessee 38112 • (901) 323-2677

APPLICATION FOR ENROLLMENT

Date of Admission	Child's Full Name Last	First	Middle Initial
Child's Date of Birth	What name does the child like to be called?		

PARENTAL INFORMATION

MOTHER'S INFORMATION	FATHER'S INFORMATION
Name _____	Name _____
Address _____	Address _____
Where Employed? _____	Where Employed? _____
Work Phone _____	Work Phone _____
Work Hours _____	Work Hours _____

TRANSPORTATION PLAN

To ensure the safety of your child, please list another adult(s) to whom your child may be released or who may be authorized to provide transportation for your child.

_____

_____

EMERGENCY INFORMATION

Name a person, other than an operator, who is authorized to act for a parent in an emergency:

Emergency Contact Name	Address	Home Telephone
Place of Employment	Work Hours	Work Telephone

PHYSICIAN'S INFORMATION

Physician's Name	Office Telephone
Address of Physician's Office	

OTHER CHILDREN IN THE FAMILY

Child's Name(s)	Date of Birth	School

BACKGROUND INFORMATION

How does the child play at home? _____

_____

Does he/she play well with children from other families? O YES O NO If YES, how does he/she play with other children? _____

_____

Is the entire family together for any time during the day? O YES O NO How long? ____

EATING HABITS

What time does the child normally eat breakfast? _____ Lunch? _____ Dinner? _____

What time(s) does the child have between-meal snacks? _____

What is his/her attitude toward eating? _____

If he/she refuses to eat, how is this handled and by whom? _____

_____

_____

Favorite foods _____

Disliked foods _____

Foods he/she is allergic to _____

(If the child is an infant, use a separate sheet for information about the formula, bottle schedule, etc.)

SLEEPING HABITS

Does the child have a room alone? ○ YES ○ NO

Does the child share a room with other children? ○ YES ○ NO

Does the child room with his/her parents? ○ YES ○ NO

Child's normal sleeping hours _____

Child's normal napping hours _____

Describe the child's general attitude toward going to bed: _____

_____

_____

If there is difficulty getting the child to go to bed, how is this handled? _____

_____

_____

TOILETING HABITS

Time(s), which the child is taken to the bathroom: _____

Does he/she go alone? ○ YES ○ NO

Does he/she have a regular bowel movement? ○ YES ○ NO

Does he/she suffer with constipation? ○ YES ○ NO If yes, how often? _____

Does he/she tell you when the need arises and goes willingly? ○ YES ○ NO

What word does he/she use for urination? _____

What word does he/she use for bowel movement? _____

SPEECH & PHYSICAL GROWTH

How does he/she talk? ○ Well ○ Fairly well ○ Not Very Well ○ Not at all

Does anyone read to him/her? ○ Yes ○ No How Regularly? _____

At what age did he/she creep? ___ Walk? ____

Please check all items that apply to your child:

○ Active	○ Quiet	○ Thin	○ Avg Weight	○ Heavy
○ Tall	○ Avg Height	○ Short	○ Friendly	○ Unfriendly

ADDITIONAL INFORMATION

Please provide any additional information that you would like for us to know about your child. _____

_____

_____

_____

_____

_____

SIGNATURE & AUTHORIZATION

My signature below indicates that I have received a copy of the licensing requirements for enrolling in First S. T. A. R. Learning Academy, that all information on this application are true to the best of my knowledge, and that I hereby authorize emergency medical care if needed.

_____ _____

Parent(s) Signature Date

FOR OFFICE USE ONLY

Date of Enrollment	Weekly Fee	Monthly Fee
Date of Withdrawal	Reason for Withdrawal	

Additional Comments by First S. T. A. R. Personnel _____

_____

_____

_____

CONSENT FOR EMERGENCY MEDICAL CARE

I, _____ do hereby request and give consent to the Director of the First S. T. A. R. Learning Academy or his duly appointed representative for _____ to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent cannot be reached.

Name of Family Doctor _____

Address _____

Office Telephone _____ Home Telephone _____

Name of person authorized to act for parent in emergency:

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Authorized Signature	Relationship	Date

RECEIPT OF POLICY STATEMENT AND LICENSING REQUIREMENTS

My signature below indicates that I have reviewed and received a copy of the Policy Statement and a copy of the "Summary of Licensing Requirements for Child Care Center".

Name of Child/Applicant _____ Signature of Parent or Guardian _____

Signature of Center Staff _____ Date _____

PERMISSION TO ATTEND ACADEMY-SPONSORED FIELD TRIPS

Child's name _____, has my permission to go on any of the scheduled outdoor activities or field trips. This may include outdoor play at the site of the First S. T. A. R. Learning Academy, or any playtime or scheduled field trips away from the premises of the day care center.

Parent/Guardians Signature _____

FIRST S. T. A. R. LEARNING ACADEMY
PERMISSION PICK-UP FORM

Child's Name	DOB	Age	Social Security Number

This form only allows for the following person(s) to pick up Child's name from First S. T. A. R. Learning Academy.

Name	Address	Phone Number
1		
2		
3		
4		
5		

Parent's Name _____

Address _____

Daytime Phone _____ Evening Phone _____

Place of Employment _____

Special Request(s): _____

_____

_____

_____

_____ _____

Parent's Signature Date

PARENT/PROVIDER PROMISE

As the Provider, I will:

* Greet each child with a smile.
* Hug each child at least once a day.
* Listen to and respect each child.
* Sincerely give each child praise.
* Discipline calmly and fairly.
* Have age-appropriate toys available for children.
* Start each day with toys picked up.
* Read aloud to the children.
* Serve nutritious, well-balanced meals and snacks.
* Start each day with a clean environment.
* End the day by telling the parent one positive thing that happened to his/her child that day.

As the Parent, I will:

* Tell the provider how I feel she is doing.
* Talk to my provider about my concerns for my child.
* Support and follow through an appropriate discipline we agreed upon.
* Bring my child appropriately dressed for the weather and the day's activities.
* Pick up my child on time.
* Call my provider when I am going to be late for either arrival or pick up.
* Pick my child up immediately when he or she becomes sick.
* Call my provider immediately when my child won't be attending.
* Inform my provider immediately of any changes in address or telephone number at home or work, or any changes in doctor or medical insurance.
* Pay my provider on time.
* Abide by my provider's contract/childcare agreement.
* Keep my child clean as to avoid any health issues.

By signing below, I agree to adhere to this promise. Failure to do so will result in finding alternate childcare arrangements.

Father/Guardian Signature	Date
Mother/Guardian Signature	Date
First S. T. A. R. Learning Academy Representative	Date

APPENDIX 6-D

CHILD'S HEALTH HISTORY CHECKLIST

Child's name _____ Birth date _____ Parent or guardian's name _____

The answer to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the right answer. We will go over the checklist with you when you have finished.

Pregnancy and Birth

Yes No 1) Were there any problems with pregnancy or your child's birth?
Yes No 2) Was his/her birth weight under 5 1/2 pounds?
Yes No 3) Did the baby have any problems in the hospital?

Medical Problems

Yes No 4) Has your child ever been in the hospital overnight?
Yes No 5) Is your child taking any medicine?
Yes No 6) Any allergies or reactions to medicine, DTP or other shots, or insects?
Yes No 7) Has your child had asthma or wheezing?
Yes No 8) Does your child have speech or hearing problems?
Yes No 9) Has your child had more than two ear infections in a year?
Yes No 10) Has your child had tonsillitis?
Yes No 11) Does your child have trouble with his/her eyes or seeing?
Yes No 12) Has your child had a bladder or kidney infection?
Yes No 13) Does he/she have burning when urinating?
Yes No 14) Does he/she have seizures, fits or shaking spells?
Yes No 15) Have you ever been told your child has a heart murmur?
Yes No 16) Is your child able to play as hard as other children?
Yes No 17) Has your child ever had a bumpy, swollen reaction to the TB skin test?
Yes No 18) Has your child ever been with anyone having TB?
Yes No 19) Has your child ever had worms?
Yes No 20) Does your child scratch his/her genital area?
Is his/her bottom or genitals red or sore?
Yes No 21) Is your child a hemophiliac (free bleeder)?
Yes No 22) Is your child on a heart monitor?
Yes No 23) Does your child have tubes in his/her ears?

Older Girls

Yes No 24) How old was your daughter when she had her first period?
Yes No 25) Does she have any problems with her period?

General Development

Yes No 26) Is your child in a special education class in school?
Yes No 27) Does your child get along with other children?
Yes No 28) Is he/she usually happy?
Yes No 29) Does your child have any special problems not indicated above?
Yes No 30) When did your child last see a doctor? _____ Month _____ Year