

Discovery Zone Kids

Evans, GA 30809

discoveryzonekids@gmail.com

Thank you for taking interest in our center. We hope that you enjoyed your visit with us. If you have not taken a tour of our facility yet, please feel free to schedule a time to visit us. We would love to have your child join us.

There are many documents here that need to be filled out. All forms are required, and all the information needs to be filled out in details as requested, so please do not leave any blanks. You may write "Not Applicable or N/A" if certain information does not apply to you.

If you are new to the area and do not have a contact person yet, please put down information of your contacts from your previous location. You can always update it later, but we must have at least one emergency contact other than the parents.

If your immunization record is from a different state, you will need to have those records transferred to a GA form. Columbia County Health Department, Eisenhour Hospital and many other medical facilities will transfer these records to a GA form. Once your child is in GA system, we will pull updated records from the data base as your child gets new shots.

If you are applying for PreK, we will need several other documents. We will need a proof of age showing that your child will be 4 years old on or before September 1 and a proof of GA residency right away. We will also need a copy of your child's social security card and a GA certificate of 4-point screening.

We do not take cash and checks. All accounts are charged on the same day each week. If bank information is provided, there is no extra charge for drafts. If credit or debit card information is provided, there is an extra fee per week. Please read details on the auto draft form. We require a non-refundable registration fee and a two-week security deposit along with the first week's tuition when your child starts attending the daycare. Please remember to fill out the EZEFT form.

We use Brightwheel App for billing and to communicate with families. This app is used to send emails and text messages. Some teachers also use them to share classroom information. This App is also used for checking in and out children from the facility. Please download it as soon as you receive the link to join us.

We have video cameras that record events most of the time. Parents do not have access to them. We view them from time to time to watch and improve our services and to investigate any incident. At other times, if parents just want to view the recording, we charge \$50 fee each time it is viewed to compensate for the time we spend on this task. Parents are usually welcome to visit the class at any time. Due to current Covid-19 issues, we are only allowing children and staff in our facility.

Discovery Zone Kids

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: _____ Father's Phone Number: _____

Father's Home Address (if different from child's) Street: _____

City: _____ State: _____ Zip: _____ Father's Email _____

Father's Place of Employment: _____ Work Phone: _____

Employer's Street Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Mother's Phone Number: _____

Mother's Home Address (if different from child's) Street: _____

City: _____ State: _____ Zip: _____ Mother's Email: _____

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: At least one emergency release contact needs to be entirely filled out with information of a person other than parents.

Name: _____ Address (Street): _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian(s): _____

Other Identifying Information (if any): _____

Name: _____ Address (Street): _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Parent(s) or Guardian(s): _____

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's Name: _____

Child's Doctor or Clinic's Phone Number: _____

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:

EMERGENCY MEDICAL AUTHORIZATION

Should (Child's Name) _____ Date of Birth _____

suffers an injury or illness while in the care of Discovery Zone Kids 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 Admin/ Person-in-charge Signature: _____ Date: _____

PARENTAL AGREEMENT WITH DISCOVERY ZONE KIDS

Discovery Zone Kids Agrees to Provide Child Care for (Child's Name): _____

on the following days of the week (circle applicable days): M T W Th F

from _____ am to _____ pm beginning the month of _____ and ending the month of _____.

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Morning Snack Lunch Afternoon Snack Evening 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), 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.

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 (**i.e. – telephone number, work location, emergency contacts, child's physician, child's health status, infant feeding plans, immunization records, etc.**).

The facility agrees to keep me informed of **any** incidents, including illness, injuries, adverse reactions to medications, etc. which includes my child.

The facility director agrees to obtain written authorization from me **before** my child participates in routine transportation, field trips, special activities away from facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the childcare 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 policy and procedures for Discovery Zone Kids. I understand that the facility 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 needs. I also understand that my participation is encouraged in facility activities.

Parent/ Guardian Signature: _____ Date: _____

Facility Administrator Signature: _____ Date: _____

Authorization to Dispense External Preparations

Aside from first aid, staff cannot dispense prescription or non-prescription medication to a child without specific written authorization which includes the full name of the child, name of the medication, prescription number, dosage, and time/date given. Parents can fill out a medication authorization form and turn it into the front office any time medication is required.

I give **Discovery Zone Kids**, 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 (i.e. A&D, Destin, Vaseline)

_____ Baby Powder

Other (please specify):

Parent/Guardian Signature _____

Date _____

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: _____

Emergency Contact(s) if parents cannot be reached:

Name: _____ Phone: _____

Name: _____ Phone: _____

Child's Doctor: _____ Phone: _____

Medical facility the center uses: Doctor's Hospital

Address: 3651 Wheeler Rd. Augusta, GA 30909

Child's Allergies: _____

Prescribed Medications: _____

Special needs/conditions: _____

In the event of an emergency involving my child, and if Discover Zone Kids 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.

Parent's Name: _____

Parent's Signature: _____

Witness By: _____ Date: _____

Parent Release Form for Media Recording

I, the undersigned, do hereby grant or deny permission to Discovery Zone Kids to use the image of my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Discovery Zone Kids website.

- Deny permission to use my child's image at all

- Grant permission to use my child's image in the following ways (mark all that apply):
 - Limited usage: I want my child's image used within the Discovery Zone Kids setting only (not in larger community)
 - Limited usage: I want my child's image used for educational materials only (not marketing). This could be either within Discovery Zone Kids or in the larger community. One example of this could be videos in parent education classes.
 - Limited usage: I want my child's image used on printed material only (no digital or video use).
 - Limited usage: I want my child's image/video used on DZK's Facebook page.
 - Limited usage: I want my child's image/video used on Daily Connect.
 - 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 Discovery Zone Kids for a variety of purposes and that these images may be used without notifying me.

I understand that a child's last name will never be used in conjunction with any video or digital images.

Parents/Guardian Signature _____ Date _____

INFANT FEEDING PLAN

Child's Full Name _____ Date of Birth _____ Date _____

Does the child take a bottle? Yes [] No []	Does the child eat: (check all that apply)?
Is the bottle warmed? Yes [] No []	Strained Foods [] Whole Milk []
Does the child hold own bottle? Yes [] No []	Baby Foods [] Table Food []
Can the child feed self? Yes [] No []	Formula [] Other []

What type of formula used, if applicable? _____

Amount and time of formula/breast milk to be given? _____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK/FOOD TO BE GIVEN

Provide prepared Formula/Breast Milk/Baby Food with your child's last name, first name and date on each container. Formula/Breast Milk will be discarded after it is served one time and left outside for an hour. Unused bottles and rinsed bottles will be sent home each day.

DATE	TIME	AMOUNT	TYPE

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

NOTE: A pacifier cannot have a toy attached to it, and it needs to be taken home each day to clean and sanitize properly.

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [] No [] Parent Initials: _____

The child has reached the following developmental skills:

Can hold his/her head steady? Yes [] No []

Opens mouth/leans forward in anticipation of food offered? Yes [] No []

Closes lips around a spoon? Yes [] No []

Transfers food from front of the tongue to the back and swallows? Yes [] No []

Instructions for the introduction of solid foods _____

Food likes _____

Food dislikes _____

Allergies? (Including any premixed formula) _____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN

Unused food will be discarded after one use if fed straight from a container.

TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed.

DO NOT SERVE THESE FOODS TO MY CHILD: (Give reason, provide a doctor's note if allergic/intolerant to certain foods and provide a signed request (parent's signature) if certain foods are not to be given because of religious reasons.

List of foods and Reason with Documentation _____

PARENT'S SIGNATURE: _____ Date: _____

Safe Sleep Practices/Policies (To be signed if enrolling an infant)

Child's Name _____

Date _____

Parent/Guardian Name _____

Safe Sleep Practices/Policies:

1. Infants will be placed on their backs in a crib to sleep unless a written physician's statement authorizing another sleep position is provided. The written statement must include how the infant shall be placed to sleep and in a time frame that the instructions are to be followed.
2. Cribs shall follow CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.
3. No objects will be placed in or on the crib with the infant. This includes, but is not limited to covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
4. No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors, and mobiles.
5. Only sleepers, sleep sacks and wearable blankets must be provided by the parent/guardian and that fit according to the commercial manufacture's guidelines and will not slip up around the infant's face may be worn for the comfort of a sleeping infant.
6. Individual crib bedding will be changed daily, or more often as needed. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. Discovery Zone Kids will provide individual cots and cribs for children. The sheets will be changed daily or more often if needed. Individual blankets for older children will be washed weekly.
7. Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will be moved to a safety-approved crib for sleep.
8. Swaddling is not permitted unless a written physician's statement authorizing it for the infant is provided. The written statement must include how the infant shall be placed to sleep and in a time frame that the instructions are to be followed.
9. Wedges or other infant positioning devices and monitors will not be permitted unless a written physician's statement authorizing it for the infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature _____

Date _____

Transportation Agreement (To be filled out for school age children)

This is to certify that I give Discovery Zone Kids permission to transport my child:

_____.

My child will be transported from _____ at _____ A.M. to _____ at _____ A.M.
Pick-up Location Drop-off Location

My child will be transported from _____ at _____ P.M. to _____ at _____ P.M.
Pick-up Location Drop-off Location

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

_____ is authorized to receive my child from the center in the event of my absence.

In the event the authorized person is not present to receive my child, the following procedures are to be followed:

The _____ is approximately _____ miles from the center.
Pick-up/Drop-off Location

In the event my child is not to be transported as outlined above, I agree to notify **Discovery Zone Kids** at **(706) 496-2489**.

Parent/Guardian _____ Date _____

Non-Discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

Additionally, program information may be made available in languages other than English.

Complaint Procedure:

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (English) or USDA Program Discrimination Complaint Form (Spanish) This form (AD-3027) is found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 6907442; or email: program.intake@usda.gov.

This institution is an equal opportunity provider. For information regarding this program, contact Jayshri Soni at 706-496-2489

Required Forms:

The center shares many required documents with this enrollment package. Some will be shared with this package that require filling out. Some will be shared electronically if they only require your signature. Please remember to sign the documents as soon as they are sent to you.

It is very important that you fill out the IES form provided to you. This form is for us to count the number of children who are coming from the low-income families. Based on the number of low-income families it serves each month, the center will or will not qualify for the food program. This status can change each month. Your information is kept confidential and is sent to state if requested.