NEW STUDENT ENROLLMENT PACKET

Updated as of 09.12.2016

LITTLELEADERSATL.COM
330 LYNHURST DRIVE
ATLANTA, GA 30311
678.710.2003

CHILD CARE SERVICE CONTRACT

This Child Care Contract ("Contract") is made effective as of ____________________, by and between the following parties:

"Provider":

LITTLE LEADERS' ACADEMY OF ARTS
ATLANTA, GEORGIA 30311
678.710.2003

AND

PARENT INFORMATION

NAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
PLACE OF EMPLOYMENT	
PRIMARY TELEPHONE NUMBER	
OTHER TELEPHONE NUMBER	
MOBILE PHONE OR BEEPER	

PARENT INFORMATION

NAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
PLACE OF EMPLOYMENT	
PRIMARY TELEPHONE NUMBER	
OTHER TELEPHONE NUMBER	
MOBILE PHONE OR BEEPER	

TO PROVIDE CHILD CARE FOR:

CHILD'S NAME	
NICKNAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
DATE OF BIRTH	
SEX	
APPLICABLE WEEKLY CHILD CARE FEE	

CHILD'S NAME	
NICKNAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
DATE OF BIRTH	
SEX	
APPLICABLE WEEKLY CHILD CARE FEE	

CHILD'S NAME	
NICKNAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
DATE OF BIRTH	
SEX	
APPLICABLE WEEKLY CHILD CARE FEE	

CHILD'S NAME	

NICKNAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
DATE OF BIRTH	
SEX	
APPLICABLE WEEKLY CHILD CARE FEE	

CHILD'S NAME	
NICKNAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
DATE OF BIRTH	
SEX	
APPLICABLE WEEKLY CHILD CARE FEE	

The undersigned Parent(s) hereby gives Little Leaders' Academy of Arts' permission to care for the above child(ren) in accordance with this Contract. In consideration of the mutual agreements and covenants contained in this Contract, the parties agree to the terms outlined in the LLA Policy & Procedures.

$	WEEK
$	DAY
$	HOUR

This contract shall be signed by the Director, on behalf of Little Leaders' Academy of Arts, and by the Parent(s) of said children. By signing this Contract, the undersigned represents that the undersigned has understood and agreed to the terms and conditions of this Contract. Breach of this Contract in any way by the Parent(s) may result in immediate termination of child care services.

LITTLE LEADERS' ACADEMY OF ARTS BY:	
PROVIDER SIGNATURE	
DATE	
NAME OF PARENT/GUARDIAN	
PARENT SIGNATURE	
DATE	
NAME OF PARENT/GUARDIAN	
PARENT SIGNATURE	
DATE	

MEDICAL HISTORY & EMERGENCY MEDICAL AUTHORIZATION

CHILD'S NAME	
BIRTHDATE	
LAST PHYSICAL EXAMINATION	
DOES YOUR CHILD HAVE ANY MEDICAL CONCERNS? HAS YOUR CHILD HAD ANY CONTAGIOUS DISEASES?	
OTHER ILLNESSES?	
HAS YOUR CHILD BEEN HOSPITALIZED? (EXPLAIN)	
HAS YOUR CHILD HAD INJURIES WITH FRACTURES OR LOSS OF CONSCIOUSNESS? (EXPLAIN)	
LAST VISION TEST DATE	
LAST HEARING TEST DATE	
LAST DENTIST VISIT DATE	
ANY OTHER MEMBERS OF YOUR FAMILY WITH SERIOUS ILLNESS RECENTLY?	

My child is currently on medication(s) prescribed for long term continuous use and/or has the following preexisting illness, allergies or health concerns:

_____

_____

The following special accommodations may be required to most effectively meet my child's needs:

_____

_____

EMERGENCY CONTACTS. In case of an emergency, Little Leaders' Academy of Arts will first try to reach the Parent(s). If the Parent(s) cannot be reached, Little Leaders' Academy of Arts will then contact the following person(s) in the order listed below:

NAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
PLACE OF EMPLOYMENT	
MOBILE PHONE OR BEEPER	

NAME	
RELATIONSHIP	
ADDRESS, CITY , STATE, AND ZIP CODE	
OTHER TELEPHONE NUMBER	
MOBILE PHONE OR BEEPER	

NAME OF PHYSICIAN	
ADDRESS CITY STATE ZIP CODE	
TELEPHONE NUMBER	

CHILD PICK-UP AUTHORIZATION FORM

CHILD'S NAME	
NAME OF PARENT	
PRIMARY PICK-UP PERSON **ADDRESS** **CONTACT NUMBER**	
SECONDARY PICK-UP PERSON **ADDRESS** **CONTACT NUMBER**	
SECONDARY PICK-UP PERSON **ADDRESS** **CONTACT NUMBER**	
SECONDARY PRIMARY PICK-UP PERSON **ADDRESS** **CONTACT NUMBER**	
SECONDARY PICK-UP PERSON **ADDRESS** **CONTACT NUMBER**	
ANY PERSON(S) NOT AUTHORIZED TO PICK UP MY CHILD/CHILDREN	
NOTE: ANY PERSON UNFAMILIAR TO LLA STAFF WILL BE REQUIRED TO SHOW PROOF OF IDENTIFICATION. UNDER NO CIRCUMSTANCES WILL THE CHILD BE RELEASED TO ANYONE OTHER THAN THOSE LISTED ABOVE WITHOUT WRITTEN PERMISSION FROM THE PARENT	
PROVIDER SIGNATURE	
DATE	
PARENT SIGNATURE	
DATE	

VEHICLE EMERGENCY MEDICAL INFORMATION

CHILD'S NAME	
CHILD'S DATE OF BIRTH	
NAME OF PARENT (S)	
ADDRESS	
CONTACT NUMBER (S)	
SECONDARY EMERGENCY CONTACT NAME	
SECONDARY EMERGENCY CONTACT NUMBER	
CHILD'S PHYSICIAN	
PHYSICIAN'S CONTACT NUMBER	
CHILD'S ALLERGIES	
CURRENT PRESCRIBED MEDICATION	
CHILD'S SPECIAL NEEDS & CONDITIONS	
MEDICAL FACILITY OF CENTER	HUGES SPALDING CHILDREN'S HOSPITAL Address: 35 Jesse Hill Jr Dr SE, Atlanta, GA 30303 Phone: (404) 785-9500 ATLANTA MEDICAL CENTER Address: 303 Parkway Dr NE, Atlanta, GA 30312 Phone: (404) 265-4000

NOTE: ANY PERSON UNFAMILIAR TO LLA STAFF WILL BE REQUIRED TO SHOW PROOF OF IDENTIFICATION. UNDER NO CIRCUMSTANCES WILL THE CHILD BE RELEASED TO ANYONE OTHER THAN THOSE LISTED ABOVE WITHOUT WRITTEN PERMISSION FROM THE PARENT

IMPORTANT ACKNOWLEDGEMENT:

IN THE EVENT OF AN EMERGENCY INVOLVING MY CHILDREN, AND IF LITTLE LEADERS ACADEMY OF ARTS CANNOT GIN 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.

WITNESS OR PROVIDER SIGNATURE	
DATE	
PARENT SIGNATURE	
DATE	

LLA/PARENT AGREEMENT FOR FOOD PROGRAM ENROLLMENT

LITTLE LEADERS ACADEMY OF ARTS AGREES TO PROVIDE CHILDCARE FOR:	
CHILD'S NAME	
ON	
DATES FOR SERVICE	
FROM	
START TIME (AM/PM)	6:00AM
END TIME (AM/PM)	7:00PM
MY CHILD WILL PARTICIPATE IN THE FOLLOWING MEAL PLAN(S):	
MEALS DESIRED (CIRCLE APPLICABLE MEALS & SNACKS)	BREAKFAST LUNCH AFTERNOON SNACK EVENING SNACK DINNER

AT THIS TIME LLA WILL NOT ADMINISTER ANY ORAL MEDICATION.

BEFORE ANY MEDICATION IS DISPENSED TO MY CHILD, I WILL PROVIDE A WRITTEN AUTHORIZATION, WHICH INCLUDES THE DATE, NAME OF CHILD, NAME OF MEDICATION, PRESCRIPTION NUMBER, DOSAGES, DATE AND TIME OF DAY MEDICATION IS TO BE GIVEN. MEDICATION 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, E.G. TELEPHONE NUMBERS, WORK LOCATION, EMERGENCY CONTACTS, CHILD'S PHYSICIAN, CHILD'S HEALTH STATUS, INFANT FEEDING PLANS, AND IMMUNIZATION RECORDS, ETC.

THE FACILITY AGREES TO KEEP ME INFORMED OF ANY INCIDENTS, INCLUDING ILLNESSES, INJURIES, ADVERSE REACTIONS TO MEDICATIONS, ETC. WHICH INCLUDE MY CHILD.

LITTLE LEADERS ACADEMY OF ARTS AGREES TO OBTAIN WRITTEN AUTHORIZATION FROM ME BEFORE MY CHILD PARTICIPATES IN ROUTINE, FIELD TRIPS, SPECIAL ACTIVITIES AWAY FROM THE FACILITY, AND WATER RELATED ACTIVITIES OCCURRING IN WATER THAT IS MORE THAN TWO (2) FEET DEEP.

I AUTHORIZE THE CHILD CARE 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 POLICIES AND PROCEDURES FOR LITTLE LEADERS ACADEMY OF ARTS. I UNDERSTAND THAT THE CENTER 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 SPECIAL NEEDS. I ALSO UNDERSTAND THAT MY PARTICIPATION IS ENCOURAGED IN THE FACILITY ACTIVITIES.

PARENT SIGNATURE	
DATE	
FACILITYADMINISTRATOR/DIRECTOR	
DATE	

TRANSPORTATION AGREEMENT

THIS IS TO CERTIFY THAT I GIVE LITTLE LEADERS ACADEMY OF ARTS PERMISSION TO TRANSPORT MY CHILD:	
CHILD'S NAME	
FROM	
PICK-UP LOCATION NAME & ADDRESS	
AT	
TIME (AM/PM)	
DESTINATION/DROP-OFF LOCATION NAME & ADDRESS	**LITTLE LEADERS ACADEMY OF ARTS 330 LYNHURST DRIVE ATLANTA, GA 30311**
ON THE FOLLOWING DAYS:	
PICK-UP DAYS (CIRCLE ALL DAYS BEING REQUESTED)	**MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**
NAME OF PERSON(S) AUTHORIZED TO RECEIVE MY CHILD IN THE EVENT OF MY ABSENCE	
ANY PERSON(S) NOT AUTHORIZED TO PICK UP MY CHILD/CHILDREN	
NOTE: ANY PERSON UNFAMILIAR TO LLA STAFF WILL BE REQUIRED TO SHOW PROOF OF IDENTIFICATION. UNDER NO CIRCUMSTANCES WILL THE CHILD BE RELEASED TO ANYONE OTHER THAN THOSE LISTED ABOVE WITHOUT WRITTEN PERMISSION FROM THE PARENT	
IN THE EVENT THAT MY CHILD IS NOT TO BE TRANSPORTED AS OUTLINED ABOVE, I AGREE TO NOTIFY LITTLE LEADERS ACADEMY OF ARTS IN WRITING.	
PARENT SIGNATURE	
DATE	

INFANT AFFIDAVIT FORM

COMMUNITY CHILDCARE FOOD SUPPLEMENT
LITTLE LEADERS ACADEMY OF ARTS

ACCORDING TO USDA REGULATIONS, AS AN INSTITUTION PARTICIPATING IN THE CHILD AND ADULT CARE FOOD PROGRAM, I MUST OFFER TO PROVIDE MEALS TO ALL INFANTS ENROLLED FOR CARE AT LITTLE LEADERS ACADEMY OF ARTS CHIL CARE FACILITY.	
LITTLE LEADERS ACADEMY OF ARTS WILL PROVIDE THE MILK AND/CEREAL AS LISTED BELOW TO ALL INFANTS ENROLLED FOR CARE AT THIS CENTER:	
CHILD'S NAME	
TYPE/BRAND MILK (MILK-BASED IRON FORTIFIED FORMULA)	
TYPE/BRAND CEREAL (IRON FORTIFIED INFANT CEREAL)	
PARENTS/GUARDIANS: PLEASE INITIAL ONE OF THE FOLLOWING *OPTIONS* BELOW	
OPTION #1 **INITIALS_____**	**I WOULD LIKE LITTLE LEADERS ACADEMY OF ARTS TO PROVIDE THE MILK-BASED IRON-FORTIFIED INFANT FORMULA AND IRON-FORTIFIED INFANT CEREAL LISTED ABOVE TO MY INFANT AND I WILL PROVIDE CLEAN, SANITIZED, AND LABELED BOTTLES DAILY.**
OPTION #2 **INITIALS_____**	**I WILL PROVIDE THE FOLLOWING MILK-BASED IRON FORTIFIED FORMULA AND IRON FORTIFIED INFANT CEREAL FOR MY INFANT ON A DAILY BASIS.**

PARENT/GAURDIAN NAME	
PARENTGAURDIAN SIGNATURE	
DATE	