ANNEEWAKEE ACADEMY
APPLICATION FOR ENROLLMENT

Child's Full Name: ________________________________ Sex of Child: ___________

Child's Address: ____
street # & name city st zip

Home Phone #:_________________________ Child's Date of Birth: _______________

Elementary School Child Attends: ____

Arrival Time to Anneewakee Academy: ______________ Departure Time: __________

First Day of Enrollment: __________________ Date of Withdrawal: _______________

YOUR CHILD WILL ONLY BE RELEASED TO THE PERSON(S) SIGNING THIS APPLICATION AND THE FOLLOWING PEOPLE (MUST BE AT LEAST 18 YEARS OF AGE). Per State Requirements, please fill in all columns completely to include full address (street, state, & zip code).

Name	Address (street, state, & zip)	Phone	Relationship

Father/Guardian Name: _____________________________________ S.S.# ______________________
Address: _________________________ City______________ Zip_____ Ph: ________________
Employed by: ___________________________________ Office Phone: ___________________
Employer's Address: _______________ City_______________ Zip_____________
Cell phone #: ______________________________ Security ID code: ________________
Email address: ____

Mother/Guardian Name: ____________________________________ S.S.# ______________________
Address: _________________________ City____________ Zip_____ Ph: __________________
Employed by: __________________________________ Office Phone: ____________________
Employer's Address: _______________ City_______________ Zip______________
Cell Phone #: _______________________________ Security ID code: _______________
Email address: ____

Child's Living Arrangements: ( )Both Parents ( )Mother ( )Father ( )Other___________

Child's Legal Guardian(s): ( )Both Parents ( )Mother ( )Father ( )Other____________

Parent's Marital Status: ( )Married ( )Single ( )Divorced ( )Widowed

Local Emergency Contacts: (Other than parent or doctor)
Name: ________________________ Hm #: _______________ Cell #: _____________________
Name: ________________________ Hm #: _______________ Cell #: _____________________

X___________________________________ **X**______________________________________
(Parent/Guardian Signature) (Date) (Parent/Guardian Signature) (Date)

CHILD'S MEDICAL INFORMATION

____ ______________________________
Child's Name Child's Date of Birth

____
Child's Physician or Clinic's Name/Child's Primary Health Source

____
Telephone No. Address

Does child have allergies or other physical problems, mental health disorders, mental retardation or developmental disabilities which would limit the child's participation in Anneewakee Academy's program and activities?

____________ YES ____________ NO

If yes, specify: ____

____

____

Does child have allergies (insects, medications, foods, etc.)? ____________ YES ____________ NO

If yes, specify: ____

____

____

Are there any special procedures required in caring for child? ____________ YES ____________ NO

Specify and give dates: ____

____

____

Are there any medications that must be administered daily on a permanent basis?

____________ YES ____________ NO

If yes, provide medication name, dosage, and times of day given: ___________________________________

____

____

Please describe any other important medical restrictions or needs that must be addressed for your child?

____

____

Signed ____ Date __________________________

MODELING RELEASE

Child's Name ____ ___________________
(Please Print) (Class Letter)

☐ I do consent to photographs and/or video footage to be used in the **center only**.
This means that pictures may be posted only within the center and on the front television.

☐ I do not consent to photographs and/or video footage to be used at all for my child.

___________________________________ _____________________
Signature of Parent/Guardian Date

___________________________________ _____________________
Witness (Director or Owner) 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 ________________________

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

Name ________________________________ Phone ______________________________

Child's Doctor ____________________________________ Phone ________________________

Doctor's Address ____

Child's Allergies ____

Current prescribed medication ____

Child's special medical needs and conditions ____

____

Medical facility that Anneewakee Academy uses: Wellstar Douglas Hospital; 8954 Hospital Dr.; Douglasville, GA 30135; 770-949-1500.

In the event of an emergency involving my child, and if Anneewakee Academy 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) ____

Date ______________________

EMERGENCY TRANSPORTATION AGREEMENT

In the event of an emergency, Anneewakee Academy has my permission to transport my child

____ by the following means

of transportation:

(Check all that apply)

_____ ambulance

_____ facility owned vehicle

_____ staff vehicle

_____ parent vehicle
(Note: Parent Vehicle means if evacuation occurs, you give permission for your child to be transported to Chapel Hill High School by an on-site parent vehicle.)

_____ Anneewakee Academy bus

____
Signature Parent/Guardian

____
Date

EMERGENCY MEDICAL AUTHORIZATION

Should ____, ______________________ suffer
Child's Name   Date of Birth

an injury or illness while in the care of Anneewakee Academy and the facility is unable to contact me immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary.

I agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of heath care is:

____   ________________________
Physician/Clinic Name   Telephone Number

Known medical conditions (i.e.) diabetic, asthmatic, drug allergies, medicines taken on a daily basis:
____

____

____

Signed _______________________________ Date _______________________

Telephone ____

PARENTS
YOU HAVE THE RIGHT:

1) TO ACCESS THIS FACILITY ANYTIME YOUR CHILD IS IN CARE. HOWEVER, YOU NEED TO IMMEDIATELY MAKE YOUR PRESENCE KNOWN TO THE PERSON IN CHARGE OF THE FACILITY.

2) TO REVIEW A COPY OF THE FACILITY'S LATEST LICENSURE EVALUATION REPORT. THE FACILITY DIRECTOR HAS THIS REPORT.

A COPY OF THE RULES AND REGULATIONS WHICH APPLY TO THIS FACILITY IS POSTED NEAR THE FRONT ENTRANCE. THESE RULES ESTABLISH MINIMUM REQUIREMENTS FOR THE HEALTH, SAFETY, AND WELL-BEING OF ALL CHILDREN IN CARE.

THE DEPARTMENT IS REQUIRED BY LAW TO INVESTIGATE ALL COMPLAINTS REGARDING RULE VIOLATIONS. THESE MAY BE ADDRESSED TO THE CHILD CARE LICENSING OFFICE LISTED IN THE STATE GOVERNMENT PORTION OF YOUR LOCAL TELEPHONE DIRECTORY.