

Date: _____

Office use only
Date Enrolled: _____

BRIGHT BEGINNINGS

Child Enrollment Information

CHILD'S INFORMATION:

Full name (as shown on birth certificate):

(First) (Middle) (Last)

Preferred name: _____

Social Security Number: _____ - _____ - _____ DOB: _____ / _____ / _____
(mm) (dd) (year)

Street Address: _____

City: _____ State: _____ Zip Code: _____

With whom does the child live?

Mother Father both other (relationship) _____

Which parent may take the child home?

Mother only Father only both

NOTE: A COURT ORDER MUST BE PROVIDED IF A PARENT IS NOT ALLOWED TO TAKE THE CHILD HOME.

PARENT INFORMATION:

Father's name: _____ DL #: _____

Street Address (if different): _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____

Home: (____) ____ - ____ Cell: (____) ____ - ____ Provider: _____

Place of employment: _____ Work: (____) ____ - ____

Other Phone: (____) ____ - ____ Email: _____

Mother's name: _____ DL #: _____

Street Address (if different): _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____

Home: (____) ____ - ____ Cell: (____) ____ - ____ Provider: _____

Place of employment: _____ Work: (____) ____ - ____

Other Phone: (____) ____ - ____ Email: _____

IN CASE OF EMERGENCY CONTACT: (when parents cannot be reached)

	<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

WHO, OTHER THAN PARENTS, IS AUTHORIZED TO TAKE CHILD HOME? (If same as emergency contact, only name needs to be listed). This person must also have photo identification when picking up your child.

	<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

MEDICAL ALERT INFORMATION:

Please list any medical, allergic, dietary, or handicapping conditions of the child.

1. _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or injured at BRIGHT BEGINNINGS, I understand that the center will: 1) contact me immediately, and 2) contact the person(s) I have designated if I cannot be reached. Should the center be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate emergency treatment.

The physician and/or medical faculty are authorized to administer emergency medical treatment to ensure the health and safety of my child.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT (continued)

I will accept responsibility for payment for medical services rendered.

Signature: _____ Relationship: _____

Date signed _____

Preferred physician: _____

Address: _____ phone: _____

Preferred hospital: _____

Note: Immunization record & physical should accompany child.

ALTERNATE NUTRITION PLAN AGREEMENT

I understand and approve the use of the alternate nutrition plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs. Indicate special dietary requirements: _____

breakfast	am snack	lunch	pm snack
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HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the Child Care Facility Brochure, "KNOW YOUR CHILD'S DAY CARE FACILITY BROCHURE/FDCH BROCHURE", and the parent's are notified in writing of the 'DISCIPLINARY PRACTICES' used by the child care facility. The parent's or legal guardian's signature certifies receipt of the childcare facility brochure/fdch brochure, discipline policies, and agreement of the alternate nutritional plan.

Signature of Parent or Legal Guardian

Date

**CGAC'S AUTHORIZATION FOR EMERGENCY
MEDICAL TREATMENT CR-5**

This form or its equivalent is required for children to receive emergency medical treatment by CGACS center.

Permission for the Director, Acting Director or the teacher to take whatever steps may be necessary for medical care in case of an emergency is hereby given. I understand that the order of actions taken will follow the outline below unless there is a need for immediate action, but will not be limited to these actions:

1. Parent or guardian will be called
2. Child's physician will be called
3. Contact person listed below will be called
4. If none of these efforts are successful, an ambulance will be called and the child will be accompanied to the emergency by a staff member.*

Name of Child: _____ Date of Birth: _____

SSN# of Child: _____

Print name of parent/guardian giving authorization: _____

Signature of the parent/guardian giving authorization: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Hospital Name: _____ Phone: _____

Emergency contact person: _____ Phone: _____

Known allergies & health conditions: _____

*Attach a copy of insurance identification card

State of: _____ County of: _____

On the ____ day of ____ 201__, before me came _____, to me known to be the individual described in and who executed the foregoing instrument and acknowledged that he executed the same.

Type of identification: _____

Signature Notary Public: _____ Print Name: _____



Bright Beginnings Daycare

An Early Learning Ministry
of Plant City Church of God

Photographs and videos are taken from time to time during birthdays, holidays, outings, and special occasions. We use these pictures/videos in our preschool for teaching, arts & crafts, albums, and various other things. In addition, pictures/videos may be posted on our website, in our yearbook, slideshows, crafts, advertisements, and on Facebook.

Child's Name: _____

Please mark:

- I **give** permission to the above named provider to take pictures/videos of the above named child.
- I **do not give** permission to the above named provider to take pictures/videos of the above named child.

I understand that these pictures/videos will not be used without my written permission.

Parent's Name: _____

Parent's Signature: _____

Date: _____