Children's Cottage Montessori
789 North Main Street
Alpharetta, GA 30201
(770) 667-3574

ENTRANCE DATE: WITHDRAWAL DATE:

CHILD'S NAME: SEX: AGE: BIRTHDATE:

HOME ADDRESS: HOME TELEPHONE:

FATHER'S NAME/HOME ADDRESS/TELEPHONE NUMBER, IF DIFFERENT FROM CHILD'S

PLACE OF EMPLOYMENT/ADDRESS OF EMPLOYMENT/BUSINESS NO.

MOTHER'S NAME/HOME ADDRESS/TELEPHONE NUMBER, IF DIFFERENT FROM CHILD'S:

PLACE OF EMPLOYMENT/ADDRESS OF EMPLOYMENT/BUSINESS NO.

CHILD'S LIVING ARRANGEMENTS: ( ) BOTH PARENTS ( ) MOTHER ( ) FATHER ( ) OTHER

CHILD'S LEGAL GUARDIAN(S): ( ) BOTH PARENTS ( ) MOTHER ( ) FATHER ( ) OTHER

THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:

NAME	ADDRESS

PERSONS TO CONTACT IN THE CASE OF AN EMERGENCY WHEN PARENTS CANNOT BE REACHED:

NAME	TELEPHONE

NAME OF PUBLIC OR PRIVATE SCHOOL CHIILD ATTENDS, IF ANY:

CHILD'S MEDICAL INFORMATION:

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE)

TELEPHONE NUMBER

DOES CHILD HAVE ALLERGIES OR OTHER PHYSICAL PROBLEMS, MENTAL HEALTH DISORDERS, MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES WHICH WOULD LIMIT THE CHILD'S PARTICIPATION IN THE CENTER'S PROGRAMS AND ACTIVITIES? ( ) YES ( ) NO

DOES CHILD HAVE ALLERGIES (INSECTS, MEDICATIONS, FOODS, ETC)? ( ) YES ( ) NO
SPECIFY:____

ARE ANY SPECIAL PROCEDURES REQUIRED IN CARING FOR CHILD? ( ) YES ( ) NO
SPECIFY AND GIVE
DATES:____

SIGNED:__________________________________ DATE:_______________________

PARENTAL AGREEMENTS WITH CHILD CARE FACILITY

1. THE CHILDREN'S COTTAGE MONTESSORI SCHOOL AGREES TO PROVIDE DAY CARE FOR

   ____ON______________________________
   NAME CHILD IS CALLED BY   DAYS OF WEEK

   ___________A.M. TO ___________P.M. FROM _____________ TO
   __________________.
   _MONTH   MONTH

   MY CHILD WILL PARTICIPATE IN THE FOLLOWING MEAL PLAN (CIRCLE APPLICABLE MEALS AND SNACKS): BREAKFAST; MORNING SNACK; LUNCH; AFTERNOON SNACK; EVENING MEAL; BEDTIME SNACK.

2. 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.
3. 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.
4. 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.
5. THE FACILITY AGREES TO KEEP ME INFORMED OF ANY INCIDENTS, INCLUDING ILLNESSES, INJURIES, ADVERSE REACTIONS TO MEDICATIONS, ETC. WHICH INCLUDE MY CHILD.
6. THE CHILDREN'S COTTAGE MONTESSORI SCHOOL AGREES TO OBTAIN WRITTEN AUTHORIZATION FROM ME BEFORE MY CHILD PARTICIPATES IN ROUTINE TRANSPORTATION, FIELD TRIPS, SPECIAL ACTIVITIES AWAY FROM THE FACILITY, AND WATER-RELATED ACTIVITIES OCCURRING IN WATER THAT IS MORE THAT TWO (2) FEET DEEP.
7. I HAVE RECEIVED A COPY AND AGREE TO ABIDE BY THE POLICIES AND PROCEDURES FOR THE CHILDREN'S COTTAGE MONTESSORI SCHOOL.

SIGNED:____
DATE:___________________________
PARENT/GUARDIAN

SIGNED:____
DATE:___________________________
FACILITY ADMINISTRATION/PERSON IN CHARGE

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EMERGENCY MEDICAL INFORMATION

CHILD'S NAME________________________ DATE OF BIRTH________________

ADDRESS____

PARENTS NAMES: (FATHER) ____

HOME PHONE: ________________________WORK PHONE__________________

(MOTHER)____

HOME PHONE: ________________________WORK PHONE__________________

IN AN EMERGENCY AND PARENTS CANNOT BE REACHED:

NAME______________________________ PHONE________________________

CHILD'S DOCTOR:_______________________PHONE_____________________

MEDICAL FACILITY THE CENTER USES: ___________________________________

ADDRESS: ____

CHILD'S ALLERGIES: ____

CURRENT PRESCRIBED MEDICATION: ____________________________________

CHILD'S SPECIAL MEDICAL NEEDS AND CONDITIONS:

IN THE EVENT OF AN EMERGENCY INVOLVING MY CHILD, AND IF CHILDREN'S COTTAGE MONTESSORI SCHOOL CANNOT GET IN TOUCH WITH ME, I HEREBY AUTHORIZE ANY NEEDED EMEREGENCY MEDICAL CARE. I FURTHER AGREE TO BE FULLY RESPONSIBLE FOR ALL MEDICAL EXPENSES INCURRED DURING THE TREATMENT OF MY CHILD.

CHILD'S NAME: ____

PARENT OR GUARDIAN: ______________________________

WITNESSED BY: ______________________ DATE: ______________

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SHOULD ______________________, ______________________ SUFFER AN
CHILD'S NAME DATE OF BIRTH

INJURY OR ILLNESS WHILE IN THE CARE OF CHILDREN'S COTTAGE MONTESSORI SCHOOL 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 RESPONSIBIILITY FOR PAYMENT AND SERVICES.

I (WE) 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 HEALTH CARE IS:

______________________ ______________________
PHYSICIAN/CLINIC NAME TELEPHONE NUMBER

KNOWN MEDICAL CONDITIONS (I.E. DIABETIC, ASTHMATIC, DRUG ALLERGIES):

____

____

SIGNED: ______________________ DATE: ______________

TELEPHONE: ______________________