LITTLE AMBASSADORS ENROLLMENT PACKET

APPLICATION

The following information is required by the Mississippi State Department of Health, Child Care Licensure Branch. This information is requested in order "to protect and promote the health and safety" of your child. Please supply a complete response to every item on this form. If the item is not applicable, please answer "N/A".

CHILD'S INFORMATION

Name: _____ Date of Birth: _____
Last First M.I.

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (___)_____ Social Security Number: _____

PARENTAL INFORMATION

Mother	Father
Name: _____	Name: _____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Cellular: _____	Cellular: _____
Pager: _____	Pager: _____
E-Mail: _____	E-Mail:_____

BUSINESS ADDRESS

Company Name_____	Company Name:_____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Cellular: _____	Cellular: _____

Hours of Care Needed: _____ Days Needed: M ____ T ____ W ____ Thur ____ F ____
Meals Needed: Breakfast _____ AM Snack _____ Lunch _____ PM Snack

EMERGENY CONTACTS

Please list at least two (2) relatives or friends who may be contacted in the event of an emergency. We will contact these individuals when the parent or guardian cannot be reached.

Name: _____ Relationship to Child: _____

Address: _____ Home Telephone: _____

_____ Work/Cellular Telephone: _____

Name: _____ Relationship to Child: _____

Address: _____ Home Telephone: _____

_____ Work/Cellular Telephone: _____

Print Name: _____ Date: _____

CHILD PICK-UP AUTHORIZATION

The persons listed below are authorized by the parents or guardians to pick up and drop off the child named on this enrollment form. This list is required by the Mississippi State Department of Health as outlined in the *Regulations Governing Licensure of Child Care Facilities.* The above named child may only be released to individuals on this list.

Name: _____ Home Telephone: _____

Name: _____ Home Telephone: _____

Name: _____ Home Telephone: _____

Name: _____ Home Telephone: _____

SPECIAL NEED INFORMATION

Please list any special need that your child may have or any information that is critical to the positive development of your child.

_____

_____

MISCELLANEOUS

I have received a copy of the Parent Handbook and a copy of the Mississippi State Department of Health Regulation Summary for Parents. I have read both of these and understand the contents of each. Yes___ No___ Initial___

Photography Authorization: (___ Not Applicable - No photographs or Video Tapes made) Yes___ No___ Initial___
I give permission for the child listed on this application to be photographed or videotaped while in attendance at this center during activities.

I give my permission for the child listed on this application to participate in field trips sponsored by this center. I understand that I will need to sign a permission slip for each field trip. Yes___ No___ Initial___

I authorize this center to administer prescription and non-prescription medication as necessary for my child. I understand that medication of all types will only be administered per published instructions, obtained either from the physician or from the original container of the medication. Yes___ No___ Initial___

I authorize this center to obtain any and all medical treatment to be performed as deemed necessary by licensed medical personnel, including medical personnel, ambulance personnel and hospital doctors and Nurses. Yes___ No___ Initial___

"Special" instructions concerning your child if medical treatment is prohibited due to religious reasons:_____

_____

My child has been toilet trained. Yes___ No___ If so, how?_____

My child will eat breakfast at the center. Yes___ No___

_____
Parent Signature Date

_____
Printed Name

_____
Center Staff

_____
Title

FOR OFFICE USE ONLY

Date of Acceptance: _____

Certificate of Immunization Form 121: Yes___ No___

Date Received: _____

Date of Withdrawal:_____

Reason for Withdrawal:_____

_____

Authorization Updates: _____

_____

LIABILITY RELEASE FORM

(Release of All Claims)

In consideration for being accepted by Jackson Revival Center Church, Inc. for participation in Little Ambassadors Developmental Learning Center, I do hereby release, forever discharge and agree to hold harmless **Jackson Revival Center Church, Incorporated,** its Pastors, Ministry Leaders, Board of Directors, After-School Care Workers, Members and Drivers thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the participant that occur while said person is participating in the above-described program including recreation and work activities. The undersigned further agrees to hold harmless and indemnify said church, its Pastors, Ministry Leaders, Board of Directors, After-School Care Workers, Members, Drivers and Agents for any liability sustained by said acts of said participant, including expenses incurred attendant thereto.

Signed _____ Dated _____

The undersigned further consents to the administration of first-aid and/or doctor's care, or any other form of medical treatment necessitated by illness or injury that may require the same. In the event of the necessity of such care or treatment as heretofore described, the undersigned agrees to hold harmless and indemnify said church, its Pastors, Ministry Leaders, Board of Directors, After-School Care Workers, Members, Drivers and Agents from any acts of malfeasance, and/or failure to act on the part of those chosen to administer medical care on behalf of the participant.

Print Child's Name:_____

Participant:_____
(Parent's/Legal Guardian's Signature)

Participant's Insurance Company:_____

Policy Number:_____

Home Telephone:_____

Work Telephone:_____

Ministry Leader/Director:_____

JACKSON REVIVAL CENTER CHURCH, INC.

Transportation and Medical Release Consent Form for Minor Child

The undersigned, give the following minor child permission to be transported by **Jackson Revival Center Church, Inc. Transportation Ministry** as part of his/her participation in the **Little Ambassadors Developmental Learning Center Program** by whatever means of transportation the church deem appropriate.

As a parent and/or guardian, I hereby authorize and direct the treatment by a qualified and licensed medical doctor of the following minor child in the event of a medical or dental emergency which, in the opinion of the attending physician, may endanger his or her life, or cause disfigurement, physical impairment, or undue discomfort if delayed. The authority is granted only after a reasonable effort has been made to reach me.

My child is subject to the following allergies or medical conditions, and I authorize the church and/or Little Ambassadors (DLC) to disclose such allergies or medical conditions to a licensed medical doctor in the event my child should require emergency medical or dental care **(please describe allergies or medical conditions with specificity):**

_____

_____

_____

_____

Name of minor:_____ Relationship:_____

Dates when release is intended: _____

This release form is completed and signed of my own free will with the purpose of disclosing medical information and of authorizing transportation and medical treatment under emergency circumstances in my absence.

Signed: _____ Date:_____
(Father/Mother/Legal Guardian)

Address: _____ Phone: _____

Family Physician: _____ Phone: _____

Additional contact in case of emergency:

Name: _____ Relationship: _____

Phone:_____

Parental Authorization

Please complete, sign and date each section of this authorization form. Each of the authorizations listed below must be updated annually as required by the Mississippi State Department of Health, Child Care Licensure Division and outlined in the *Regulations Governing Licensure of Child Care Facilities.*

Pick Up and Drop Off List

Child's Name:_____

The following people may pick up or drop off my child at this child care facility:

_____

_____

I do ___ do not ___ give permission for my child _____ to be photographed or videotaped while in attendance at _____ center during center activities.

Signature: _____ Date:_____

Field Trip Authorization (___ Not Applicable)

My child _____ does ___ does not ___ have permission to participate in field trips sponsored by _____ center. I under stand that I will need to sign a permission slip for each field trip.

Signature: _____ Date:_____

Medication Authorization (___ Not Applicable)

I authorize _____ center to administer prescription and non-prescription medication as necessary for my child. I understand that medication of all types will only be administered per published instructions, obtained from the physician or from the original container of the medication.

Signature: _____ Date:_____

Emergency Medical Treatment Authorization

I authorize _____ center to obtain any and all medical treatment to be performed as deemed necessary by licensed medical personnel, including emergency medical personnel, ambulance personnel and hospital doctors and nurses.

Signature: _____ Date:_____

PARENTAL AUTHORIZATIONS - UPDATES

Complete at least annually

Child's Name: _____ Date of Birth: _____

The following people are allowed to pick up and drop off my child:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

My child may be photographed/video taped at the facility ___ Yes ___ No
By the media ___ Yes ___ No

My child may participate in approved field trips sponsored by the facility ___ Yes ___ No
I understand a separate permission form must be signed for each field trip.

The facility has my permission to obtain emergency medical treatment for my child
___ Yes ___ No

If no, list instructions _____

Two (2) emergency contacts if the parent(s) or guardian(s) can not be located promptly:

Name: _____

Address: _____

Telephone: _____

Name: _____

Address: _____

Telephone: _____

_____ _____
(Parent Signature) (Date)

Does your child have allergies? _____ yes _____ no Please list, including food, if necessary:

_____

_____

_____

My child is toilet trained _____ Yes _____ No.

If no, a consultation between the parent and caregiver is required to be documented prior to toilet training and kept on file.

Date of consultation _____/_____/_____.

My child will eat breakfast at the center _____ Yes _____ No. If no, my child will eat BEFORE coming into the center.

Parent Signature: _____ *Date:* _____

Director Signature: _____ *Date:* _____

FOR OFFICE USE ONLY:

Record updated & signed by parent if no changes (once a year):

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

DIRECTOR USE ONLY:

Enrollment Date: _____/_____/_____ Start Date: _____/_____/_____ Withdrawal Date: _____/_____/_____

Incident Report Form

Personal Information

Name of Person: _____ Person Making Report: _____
Last First M.

Parent/Guardian's Name: _____ Telephone No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Incident: _____ Time of Incident: _____ a.m.___ p.m. ___

Date & Time of Report: _____ a.m. ___ p.m. ___ Parent Notified: _____ a.m.___ p.m. ___

Brief Description of the Incident

Name of Incident: _____

_____

_____

_____

Activity Immediately Before and at the Time of the Incident: _____

Action Taken by Center Staff:

_____ Written Incident Report _____ Parent Conference

_____ Suspension from the Center/Program _____ Withdrawal from the Center

_____ Period of Time

Witnesses to the Incident

Name of Person: _____ Name of Person: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Telephone: _____ Telephone: _____

The Child Care Facility has the responsibility to insure the safety of all the participants in its programs. This incident report is to inform you that the behavior outlined above can not and will not be tolerated in any program sponsored by this Child Care Facility. This facility must ensure the "health and safety of the children" enrolled here, and continued behavior of this nature may result in you or your child being suspended temporarily or permanently from programs and facilities owned by the Child Care Facility.

Please give a copy to the parents and keep a copy for your files

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Child Care Facilities Accident Report

Child's Name: _____

Parent/Guardian Name: _____ Telephone No.: _____

Address: _____

Date of Accident: _____ Time of Accident: _____ a.m.___ p.m. ___

Time Parent Notified: _____ a.m.___ p.m. ___ Number of Attempts to Notify: _____

Time Child Left Child Care Facility: _____ a.m.___ p.m. ___ With Whom _____
Parent, Emergency Medical Transportation

Description of Injuries: _____

_____

Action Taken at Home or Center (*first aid):* _____

_____

Doctor/Nurse Consulted: _____

Doctor's/Nurse's Diagnosis: _____

_____

Number of Days Missed From Child Care Facility as a Result of Accident: _____

Adult in Charge When Accident Occurred: _____

Description of Activity, Location in Facility and Circumstances, Immediately Before and at the Time of the Accident: _____

_____

_____

What Corrective Measures Could be Taken to Eliminate Such Accidents in the Future? _____

_____

Center: _____License No.: _____

Street: _____ City: _____

County: _____ Zip: _____

Report Prepared by: _____ Date: _____

Date Submitted to Mississippi State Department of Health: _____

Attach Statements by Staff Supervising Child and All Staff Witnessing Incident