



Enrollment Application

Child Information

Stepping Stones Academy
...itty bitty steps towards success

Date: _____

| | | | |
|--|--------|----------------|------------|
| Name of Child: | | Date of Birth: | Gender: |
| Street Address: | | | |
| City: | State: | Zip Code: | Telephone: |
| Parent's primary email address (for internal correspondence only): | | | |
| Name of Elementary School Attending (if any): | | | |

Enrollment Information

| | |
|-----------------------------|----------------------------------|
| Date Attendance Will Begin: | Days and Duration of Attendance: |
|-----------------------------|----------------------------------|

Parent Information - Mother

| | | | |
|---|-------------|----------------|-----------------|
| Mother's Name: | | | |
| Home Phone: | Cell Phone: | Email Address: | |
| Home Address (if different from child): | | | |
| Employer: | | Work Hours: | |
| Street Address: | | | |
| City | State: | Zip Code: | Work Telephone: |

Parent Information - Father

| | | | |
|---|-------------|----------------|-----------------|
| Father's Name: | | | |
| Home Phone: | Cell Phone: | Email Address: | |
| Home Address (if different from child): | | | |
| Employer: | | Work Hours: | |
| Street Address: | | | |
| City | State: | Zip Code: | Work Telephone: |

Family Information

| | |
|---|------------------------------|
| Marital Status of Parents: | Names of Brothers & Sisters: |
| Stepfather's Name: | Stepmother's Name: |
| Is your child adopted? | Do they know? |
| Child's Living Arrangements: Both Parents () Mother () Father () Other: | |
| Child's Legal Guardian(s): Both Parents () Mother () Father () Other: | |
| Are there any social or family circumstances that Stepping Stones Academy should be aware of? | |

Health Information

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|--|
| Describe any health conditions or other situations concerning your child which Stepping Stones Academy should be aware that would require special procedures to be followed. Please include physical or mental issues that may limit the child's participation in programs and/or activities and any dietary restrictions. |
| Please list any and all allergies. |
| Please list any dietary restrictions: |
| What protocol should be taken if allergic reaction occurs? |
| Please list any medication(s) prescribed for long-term, continuous use: |
| Please list any general health issue(s) we should be aware of: |

Physician Information

| | |
|--|-------------------|
| Name and telephone of the physician / clinic you wish for us to contact in an emergency situation: | |
| Physician / Clinic Name: | Telephone Number: |

Emergency Contacts

| | | |
|---|------------------------|------------|
| Persons whom you authorize Stepping Stones Academy to contact for guidance in a medical or other emergency if the child's parents/guardians can not be reached: | | |
| Name: | Relationship to Child: | Telephone: |
| Name: | Relationship to Child: | Telephone: |
| Name: | Relationship to Child: | Telephone: |

Release Authorization

Please list the persons other than the parent/guardian to whom Stepping Stones Academy is authorized to release your child. Stepping Stones Academy will not release your child to anyone that is not identified below without written, signed authorization from the parent/guardian. Changes to this list of persons appearing below will be made, signed and dated on this form or shall be attached. The parent/guardian agrees that he/she will be certain the staff is aware of the child's arrival and departure each day and to escort their child into and out of the school when dropping off or picking up. Stepping Stones Academy will not allow any child to enter or leave without an escort.

| | | |
|----------|------------------------------------|------------------------|
| Name: | Relationship to Parent / Guardian: | Relationship to Child: |
| Address: | | Telephone: |
| Name: | Relationship to Parent / Guardian: | Relationship to Child: |
| Address: | | Telephone: |

Agreement

I hereby agree with any and all statements and provisions made herein. I hereby further attest that all the information I have provided herein is true and accurate to the best of my knowledge and that I shall notify Stepping Stones Academy of any changes in timely manner.

Mother/Guardian Signature: _____ Date: _____

Father/Guardian Signature: _____ Date: _____



Program Information

Enrollment Agreement

Date: _____

| | | |
|-----------------------------|---------------------|------------------------|
| Name of Child: | | |
| Program: | Days of Attendance: | Weekly Tuition Amount: |
| Date Attendance Will Begin: | Signature: | |

Fees

| Fee/Charge | Amount | Provisions |
|--|--|---|
| Registration & Enrollment Fee | \$375.00 per child \$75 each additional child | Nonrefundable Paid within 24 hours of acceptance of opening |
| Tuition | As stated herein | Due weekly on MONDAY for the upcoming week Meals included based on Program (breakfast, lunch & afternoon snack) |
| Vacation Time | 50% off week | Each family earns a 50% off week every 6 months, must use within one calendar year. |
| Field Trip & Summer Camp | As published | Charged on a per event basis |
| Late Payment Charge | \$10.00 per day | Assessed if account balance is unpaid as of Monday at 12 p.m. |
| Late Pickup Charge | \$5.00 for every 5 minutes | Assessed each minute a child remains on school premises past normal operating hours and/or part-time program hours |
| Returned Check Fee | \$35.00 per occurrence | Multiple occurrences of returned checks may result in cash payment being required until such time as consistent, on-time payment record is restored |
| Accounts ten (10) or more days delinquent shall result in suspension until such time as account balance is paid in full. Accounts thirty (30) or more days delinquent may result in disenrollment. We reserve the right to increase tuition and other charges upon one month's prior written notice. | | |
| ABSENCES- Tuition must be paid in full without deduction for absences of any duration or for any cause, and without substitution of other days of attendance as "make-up" days. We offer a 50% off vacation week after 6 months of enrollment, must use within one calendar year. | | |
| WITHDRAWAL- The obligation for full payment of tuition continues until the date indicated by the parent or guardian as the date of withdrawal. The parent or guardian agrees to furnish SSA with at least 30 (thirty) days written notice of such date of withdrawal. | | |
| Acceptable forms of payment for all fees are cash, check, or online ACH payments. | | |

Stepping Stones Academy is open Monday – Friday
6:30 am - 6:30 pm 12 months a year.



Enrollment Acknowledgement and Agreement

I grant permission for my child to participate in the above referenced program activities, including the use of indoor and outdoor equipment, and I agree to pay all fees associated with the enrollment of my child at Stepping Stones Academy.

Before any medication is dispensed to my child, I will provide a written authorization which includes, but is not limited to: date, name of child, name of medication, prescription number (if any), dosage, date and time of day medication is to be given. All 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)/guardian(s), person authorized by the parent(s)/guardian(s), or Stepping Stones Academy personnel.

I acknowledge that it is my responsibility to keep my child's records current to reflect any changes as they occur, such as telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunizations, etc.

I acknowledge that I have received a copy of the Stepping Stones Academy Parent Handbook and I shall abide by the statements, provisions, policies and practices therein.

Stepping Stones Academy agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, and exposure to communicable disease, which include my child.

Stepping Stones Academy agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the school, and water-related activities occurring in water more than two (2) feet deep.

I acknowledge that Stepping Stones Academy will advise me of my child's progress and keep me informed of any issues or special needs relating to my child's care.

I understand that my participation is encouraged in Stepping Stones Academy activities.

Mother/Guardian Signature: _____

Date: _____

Father/Guardian Signature: _____

Date: _____

Director Signature: _____

Date: _____

Stepping Stones Academy understands that it is difficult for parents to leave or miss work due to the illness of their child. We recommend that alternative childcare arrangements be available for occasions when your child needs to remain at home or be picked up due to illness. If the parents or guardians travel or are unable to be reached for long periods of time, it is important to have an emergency contact, who will be able to respond to their child's needs their absence.

In order to comply with the requirements imposed by the state-licensing agency, if your child has any of the following conditions or symptoms, you will be contacted to pick up the child within 1 hour of notification. During this time, your child will be removed or isolated from the other students and kept as comfortable as possible.

- A fever of 101 or above with or without additional symptoms (rash, vomiting, diarrhea, etc.)
- Vomiting with or without additional symptoms (fever, rash, diarrhea, etc.)
- Loose or uncontrolled bowel movements (diarrhea) with or without additional symptoms
- A skin rash, lesion or wound with bleeding, oozing, pus, or clear fluid
- Conjunctivitis / Pink Eye where whites of the eye appear red and/or blood shot accompanied by discharge that is white, yellow, or green in color
- Nasal discharge that is constant, uncontrolled, thick, and green in color
- A cough that is constant, uncontrolled, and productive (raising phlegm)
- Any contagious or communicable illness or disease, which is reportable to the Department of Public Health
- Children lethargic wanting to sleep and not participate in activities

A list of communicable diseases is posted at the school and copies are available.

If a child is diagnosed with any of the above conditions, his/her pediatrician can provide guidance concerning his/her return to school. If your child's doctor has identified a communicable disease, please notify Stepping Stones Academy so that we can post a notice on the classroom door alerting others to watch for symptoms in their child.

In order for a child to return to school, the following conditions imposed by the state-licensing agency must be met:

- The child must be fever and/or symptom free for a full 24 hours. If a child returns to school within the 24 hours after being sent home, he/she will be sent home.
- Any prescribed medication for a current contagious condition must be taken for a full 24 hours before returning.
- For certain conditions, the Director may require a statement from your child's doctor before readmission will be authorized.

All prescription and over-the-counter medications will be administered to a child only upon written authorization by the parent or guardian using the Medication Authorization form. State law requires that all medications must be:

- In the original container; and clearly labeled with the name of the child, the name of the medicine, the prescription number (if a prescription) and the date and dosage to be administered

Medicines shall administered at 11:00 a.m. and 3:00 p.m. as follows:

- Prescription medications will be given per the dosage and time period instructions on the label.
- Over-the-counter medications, creams, ointments, etc. will be given for 3 days, after which written instructions from the child's doctor will be required for the medication to continue. These instructions must include name of the medication, dosage amount, dosage quantities and dates and/or length of time to be administered.

Prescription medicine that is to be administered on a long-term basis (asthma, allergies, etc.) will require instruction from the child's doctor and an action plan. These instructions must include the condition that requires the medication, name(s) of medicine, dosage amount, dosage quantities and if this is a seasonal, on going or permanent condition.

Parent Signature _____ Date _____

Child Information



Emergency Medical & Transportation Agreement

Date: _____

| | | | |
|---|--------|----------------|------------|
| Name of Child: | | Date of Birth: | Gender: |
| Street Address: | | | |
| City: | State: | Zip Code: | Telephone: |
| Name of Elementary School Attending (if any): | | | |
| Allergies or Medical Conditions: | | | |
| Current Prescribed Medication: | | | |

Parent Contact Information

| | | | |
|----------------|-------------|-------------|-------------|
| Mother's Name: | Home Phone: | Work Phone: | Cell Phone: |
| Father's Name: | Home Phone: | Work Phone: | Cell Phone: |

Physician Information

| | |
|-----------------|------------|
| Physician Name: | Telephone: |
|-----------------|------------|

Emergency Contacts

| | | |
|---|------------------------|------------|
| Persons whom you authorize Stepping Stones Academy to contact for guidance in a medical or other emergency if the child's parents/guardians can not be reached: | | |
| Name: | Relationship to Child: | Telephone: |
| Name: | Relationship to Child: | Telephone: |
| Name: | Relationship to Child: | Telephone: |



Emergency Medical Agreement

I understand that consistent with the circumstances of the situation and available time, if the above named child is injured or becomes ill, Stepping Stones Academy will attempt to contact and follow the instructions of the parent or guardian, physician or other person(s) designated as outlined above.

In the event Stepping Stones Academy is unable to contact the parent or guardian, physician or emergency contact person(s), or the circumstances of the situation require immediate action, I hereby authorize Stepping Stones Academy to contact and comply with the advice of an available physician, ambulance personnel or emergency room personnel.

I further understand that Northside Hospital, located at 1000 Johnson Ferry Rd NE Sandy Springs GA, 30342, 404-851-8000 is the emergency medical facility utilized by Stepping Stones Academy. If Northside Hospital is unable to contact me, I hereby authorize any needed emergency medical care for the above-mentioned child.

I agree that I shall be fully responsible for all medical expenses incurred by all parties during the treatment of the above-mentioned child.

Mother/Guardian Signature: _____ Date: _____

Father/Guardian Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Emergency Transportation Agreement

In the event of a non-medical emergency, such as evacuation, I hereby agree that Stepping Stones Academy may transport the above referenced child to Swift Learning Center, located at 300 Grimes Bridge Road, 678-205-4988, or any secondary location that Stepping Stones Academy, in its sole discretion, deems safe.

Mother/Guardian Signature: _____ Date: _____

Father/Guardian Signature: _____ Date: _____

Witnessed by: _____ Date: _____



Photo Release Agreement

Date: _____

Child Information

Name of Child: _____

Photo Release Agreement

I hereby grant to Stepping Stones Academy the right to make, use and publish photographs of my child, or in which my child may be included, for center publications, electronic reproductions (web sites), promotional materials and/or any other purpose.

I hereby further grant permission to alter the same without restriction and to copyright the same.

I hereby further release the photographer and Stepping Stones Academy from all claims and liability relating to said photographs.

Mother/Guardian Signature: _____ Date: _____

Father/Guardian Signature: _____ Date: _____



Parental Authorization to Dispense External Preparations

Date: _____

I give Stepping Stones Academy permission to apply one or more of the following topical ointments/preparations to my child, as necessary, in accordance with the directions on the label of the container:

_____ Baby wipes

_____ Band-aids

_____ Neosporin or similar antibiotic ointment

_____ Peroxide or similar first aid spray/liquid

_____ Sunscreen

_____ Insect repellent

_____ Non-Prescription ointment (such as A&D, Desitin, Vaseline)

_____ Baby powder

_____ Saline

_____ Other: please specify _____

Print Child's Name

Parent's Signature

*Form will be kept in student's file and must be updated every 12 months or more often as needed.



INFANT FEEDING PLAN

Child's full name _____ Date _____ Date of Birth _____

Does child take bottle? Yes No

Is the bottle warmed? Yes No

Does the child hold own bottle? Yes No

Can the child feed self? Yes No

Please wake up my child if they are sleeping and it is time for them to eat. Yes or No

Length of time to let my child sleep past their feeding time _____ minutes

Does the child eat: (Check all that apply)

Strained foods Baby foods Formula Breast Milk Whole milk Table foods Other

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk:

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Does the child take a pacifier? Yes No If yes, when? _____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula) _____

| Formula/Breast Milk | | | Food | | |
|---------------------|--------|------|------|--------|------|
| Time | Amount | Type | Time | Amount | Type |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Instructions for the introduction of solid food _____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed _____

PARENTS' SIGNATURE: _____ Date: _____



Safe Sleep Practices Policy

Child's Name: _____ Date of birth: _____

Parent/Guardian Name: _____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPSC and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will be moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature _____ Date _____