



The Learning Academy of College Park
Registration Checklist 2011-12 School Year

- First tuition installment. Make your check payable to *The Learning Academy of College Park*.
- Completely fill out the Registration Form.
- Make your check payable to *The Learning Academy of College Park* for your child's/children's registration fee(s), if applicable. **Registration fees for each child must accompany registration forms for placement to be guaranteed.**
- Thoroughly read the school Handbook and familiarize yourself with the calendar and policies & procedures of the school. Sign and return the last page to the office.
- Fill out Additional Student Information Form
- Fill out The School as a Community Form
- Completed Authorized Adults Form
- Completed Emergency Information Form
- Completed Emergency Medical Authorization Form
- Children 6weeks through Pre-K **must** provide a current certification of immunization (Form 3231 only).

Richard Pflieger
Director

Rev. Beth Sanders
Pastor

**The Learning Academy
Of College Park**



**Office Use Only
Registration Fee**

\$75.00

Materials/Book Fees

\$125.00

2011-2012 Registration Form

Student's Full Name _____
Last First Middle Name child responds to

Male Female Age _____ Date of Birth _____ SS# _____
Mo/Day/Year

Present Address _____
Street City State Zip Code

Home Phone _____ Mom Cell _____ Dad Cell _____ work #1

work # 2

E-Mail Address #1 _____ E-Mail Address #2 _____

Last School Attended _____
Name Address
City State Zip Code

Bright Beginnings **Toddlers** **Taking Charge** **Transitioning** **Pre-K**

Last Name	First Name	MI	Place of Employment	Work Address
Parent				
Parent				
Guardian				

Marital Status: Married Divorced Separated Single

With which parent or guardian does the child reside? _____

Parents/Guardian's Address & Phone # If Different from Child's:

Health Needs

List Medications Taken Regularly (What, How Often, For What Purpose)

Allergies _____

Chronic Illness _____

Is there anything else you would like us to know about your child?

Hobbies/Interests

Please list your child's hobbies and interests.

Educational Goals

What are some of your goals for your child?

What are some important factors in the education of your child?

How will you contribute to the growth of the school and ultimately your child?

EMERGENCY INFORMATION RECORD

Insurance Company _____

Insurance Company Policy # _____ **Group #** _____

Please fill out and return to the teacher

Name: _____ **Emergency Phone #** _____
(Parent or Guardian)

Home Address: _____ **Home Phone #** _____

Mother's Business Phone: _____ **Cell Phone #** _____

Father's Business Phone: _____ **Cell Phone #** _____

Student's Physician:
Name: _____ **Phone #** _____

Hospital where student should be taken if parent or physician is unavailable:

Allergies & Other Medical Condition (check & explain or list):

--Allergies _____

--Epilepsy _____

--Asthma _____

--Heart Problems _____

--Recurring Illness _____

--Diabetes _____

--Dental Appliances _____

--Special Medications _____

--Other _____

Other contact in case of emergency _____

Name & Relationship _____ **Phone** _____

Signature of Guardian or Parent _____

Permission to obtain any emergency/medical or hospital aid for my child (Yes) (No)

Insurance Company Policy # _____ **Group #** _____

AUTHORIZED ADULTS TO PICK UP CHILD

In accordance with Georgia law, we must have on file the names, addresses, and telephone numbers of the individuals permitted to drop off and pick up your child/children from our program. Individuals, who present themselves to claim your child, who have not been authorized by you, will not be allowed to leave with your child. Please list any persons any person's name, address, and telephone number who might arrive to pick up your child. Also, please call us if your child will not be in attendance of school.

Thank you for your cooperation.

Child's Name: _____

The following adults may drop off or pick up my child from The Learning Academy of College Park:

1) Name _____ Relationship to child

Address _____
Phone _____

2) Name _____ Relationship to child

Address _____
Phone _____

3) Name _____ Relationship to child

Address _____
Phone _____

(Additional authorized adults can be added to the back of the paper)

FOR THE SAFETY OF YOUR CHILD/CHILDREN, ALL INDIVIDUALS (OTHER THAN PARENTS OR GAURDIANS) WHO ARRIVE TO PICK UP YOUR CHILD WILL BE ASKED TO PRESENT A VALID FORM OF IDENTIFICATION.

I understand that my child will not be released into custody of any person who is not on the above list. I also understand that it is my responsibility to inform the school of any changes that need to be made to the above list.

Parent's or Guardian's Signature: _____

Parent's or Guardian's Name Printed: _____

EMERGENCY MEDICAL AUTHORIZATION

CHILD'S NAME

PARENT'S/GUARDIAN'S NAME

AGE & DATE OF BIRTH

ADDRESS

INSURANCE COMPANY

POLICY NUMBER

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become seriously ill or injured while under the supervision of The Learning Academy of College Park, when the parent or guardian can not be reached.

I (parent/guardian) _____, authorize that in the event that I or my other emergency contact person is unable to be contacted and my child is seriously injured or becomes seriously ill, he/she may be taken to **Children's Health Care of Fayette**. I also hereby give my consent for the administration of any treatment deemed necessary by the attending licensed physician.

This authorization does not cover major surgery unless the medical opinions of the attending licensed physicians concurring in the necessity of such surgery. Every attempt will be made to contact the parent or guardian to obtain permission prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment will be taken with the child. The Director or Teacher will accompany the child in the event of this emergency.

Date

Signature of Parent or Guardian

I do not give my consent for emergency treatment of my child.

Date

Signature of Parent or Guardian

AUTHORIZATION FOR DISTRIBUTION OF PRESCRIBED MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time(s) Medication is to be given: _____

Dosage of Medication to be given: _____

Dates to be given: _____

Signature of Parent/Guardian

Date

- **ANY PRESCRIBED MEDICATION MUST COME TO SCHOOL IN ITS ORIGINAL PRESCRIPTION CONTAINER.**

FOR SCHOOL USE ONLY

Date	Time Given	Dosage	Adverse Reaction	Administered By

If noticeable adverse reaction to medication was observed, what action was taken? Describe

The Learning Academy
of College Park



The School as a Community

School Publications

_____ **Yes** _____ **No** I hereby give my permission for my child and myself to have our photographs and/or names appear in school publications (i.e. school brochure, yearbook, Happenings Newsletter, website, and other publications that are education related).

May we publish your home number and address in the student directory? YES NO

Family Participation

As a school community, The Learning Academy has various functions to which immediate family members, grandparents, and friends are invited. Please provide the following information:

Siblings

Name _____ Age _____ School _____

Name _____ Age _____ School _____

Name _____ Age _____ School _____

Maternal Grandparents

Name _____

Address _____

Phone _____

Paternal Grandparents

Name _____

Address _____

Phone _____

How did you hear about The Learning Academy of College Park?



Additional Student Information

HAS YOUR CHILD EVER BEEN TESTED BY ANOTHER SCHOOL?

YES

NO

If yes, where? SCHOOL NAME _____

SPECIAL NEEDS

Has your child ever been tested for any of the following special needs:

Learning Disabilities: _____ Yes _____ No Place _____
Date _____

Speech/Language Disabilities: _____ Yes _____ No Place _____
Date _____

Attention Deficit Disorder: _____ Yes _____ No Place _____
Date _____

Hyperactivity: _____ Yes _____ No Place _____
Date _____

Has medication been prescribed for your child related to ADD/ADHD?
_____ Yes _____ No

Is your child currently **taking** making medication for ADD/ADHD?
_____ Yes _____ No

If you answered yes to any of the above questions, please share with us all information obtained from these evaluations.

Are there any situations or pertinent information which we should know in order to further understand your child?

I have truthfully answered all of the above questions.

I have included all educational testing information and results concerning my child.

Parent's Signature

Child's Name

INCIDENT REPORT

In the event that your child is involved in an incident involving some form of injury you will receive an incident report and another copy will be placed in your child's records.

Name of Student: _____

Date: _____

Time of Incident: _____

Teacher: _____

Witness: _____

Injured Body Part: _____

Was Parent/Guardian Called YES NO

Were EMTs Called YES NO

Description of Incident:

What type of first aid was administered?

