2021-2022 School Year

TURNING POINT
LEARNING CENTER

1415 Bass Rd, Macon, GA 31210
Office: (478) 474-7487
Fax: (478) 474-7335

Start Date _____ **Withdrawal Date** _____

Child's Name_____ **Goes By**_____ **Sex**_____

Date of Birth_____ **Age (as of September 1)**_____

Home Address _____

Father's Name_____ **Phone**_____

Father's Home Address (if different from child's) _____

Father's Place of Employment_____ **Work Phone**_____

Father's Email Address: _____

Mother's Name_____ **Phone**_____

Mother's Home Address (if different from child's) _____

Mother's Place of Employment_____ **Work Phone**_____

Mother's Email Address: _____

Child's Living Arrangements (circle one): **Both Parents** **Mother** **Father** **Other**

Child's Legal Guardian(s) (circle one): **Both Parents** **Mother** **Father** **Other**

The child may be released to the following person(s):

Name_____ **Phone**_____

Address_____

Relationship to child_____ **Relationship to Parent/Guardian**_____

Name_____ **Phone**_____

Address_____

Relationship to child_____ **Relationship to Parent/Guardian**_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____ **Phone**_____

Name_____ **Phone**_____

Name_____ **Phone**_____

MEDICAL INFORMATION

Child's Doctor or Clinic Name_____ **Phone**_____

Allergies and/or food restrictions _____

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center _____

_____

My Child is currently on medication(s) prescribed for long-term continuous use and/or has the following preexisting illness, allergies, or health concerns_____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ **Date of Birth**_____ **suffer an injury or illness while in the care of TURNING POINT LEARNING CENTER 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 responsibility for payment of services.**

Parent/Guardian_____ **Date**_____
Signature

Facility Director_____ **Date**_____
Signature

Parental Agreements with Child Care Facility

The Turning Point Learning Center agrees to provide day care for _____
(Name of Facility) (Name of Child)

on _____ _____ a.m. to _____ p.m. from January to December
(Days of Week) (Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast

Morning Snack

Lunch

Afternoon Snack

Evening Snack

Dinner

Bedtime Snack

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; dosages; date and time of day medications is to be given. Medicine 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), person authorized by parent(s), or facility personnel.

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.

The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medications, etc., which may include my child.

The Turning Point Learning Center 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 than two (2) feet deep.

I authorize the childcare facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for Turning Point Learning Center.
(Name of Facility)

I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed_____ Date_____
(Parent/Guardian)

Signed_____ Date_____
(Facility Administrator/Person-In-Charge)

SAFE SLEEP PRACTICES

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 CPCS 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.

Signed_____ Date_____
(Parent/Guardian)

INFANT FEEDING PLAN

Child's Full Name_____ Date_____

Date of Birth_____

Does the child take a bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat (check all that apply):

Strained Foods	[ ]	Whole Milk	[ ]
Baby Food	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type of formula use, if applicable? _____
Amount and time of formula/breast milk to be given?_____ Date_____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

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

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials_____

The child has reached the following developmental skills:

Can hold his/her head steady?	Yes [ ]	No [ ]
Opens mouth/leans forward in anticipation of food offered?	Yes [ ]	No [ ]
Closes lips around a spoon?	Yes [ ]	No [ ]
Transfers food from front of the tongue to the back and swallows?	Yes [ ]	No [ ]

Instructions for the introduction of solid foods_____
_____

Food likes_____

Food dislikes_____

Allergies (including any premixed formula)_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

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

Parent's Signature_____ **Date**_____

Authorization to Dispense External Preparations

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of medication' prescription number, if any dosage; the dates to be given; the time of day to be dispensed; and signature of parent/guardian.

I give Turning Point Learning Center, my permission to apply one or more of the following topical ointments/prescriptions to my child in accordance with the directions on the label of the container.

____ Baby Wipes

____ Band-Aids

____ Neosporin or similar ointments

____ Bactine or similar first aid spray

____ Suncreen **(Parent must provide bottle with child's full name written on it)**

____ Insect Repellant **(Parent must provide with child's full name on it)**

____ Non-Prescription Ointment **(such as A & D, Destin, Vaseline, Maalox for diaper rash etc)**

____ Baby Powder

____ Other **(Please specify)** _____

_____	_____	_____
Child's Name	Parent's signature	Date

Media Release Form

I _____, give Turning Point Learning Center
Permission for my child's video image, photographed image and artwork to be displayed and used for purposes of promoting Turning Point in (but not limited to) newspapers, social media (*facebook, Instagram,Turning Point website/Church website*) and local news.

Child's Name _____

_____	_____	_____
Parent's Name (Print)	*Parent's Signature*	*Date*

_____	_____	_____
Director's Name (Print)	*Director's Signature*	*Date*

Turning Point Learning Center does not discriminate against applicants and students on the basis of race, color, and national or ethnic origin. The Turning Point Learning Center is not equipped to care for the specials needs of physically and /or mentally challenged children.

Turning Point Learning Center requires that each child enrolled must have an up to date Immunization on file (Form 3231) in the school office.

The registration fees secures a place for you child and is non-refundable. To withdraw your child from TPLP, a 2 Week advance written notice is required. Tuition and fees must be current through the last month attending. Tuition and fees are still due for withdrawals that occur without a 2 Week notice. There will be no adjustments made for absences, illnesses, closures due to weather, or family vacations. In general, we try to follow the Bibb County school calendar for holidays and school closures. **Please refer to your parent handbook for a copy of our school calendar**.

WAIVER OF LIABILITY: In the event that I cannot be reached and my child needs emergency treatment, I authorize an attending physician at the nearest emergency room to administer necessary treatment to my child. I agree to assume all financial responsibility. I will hold harmless Turning Point Learning Center and its staff, Turning Point at Mabel White, its staff and Board of Elders and Deacons, and The Southern Baptist Convention, for any accident or injury that may occur to my child while attending Turning Point Learning Center.

My signature below indicates that I have read the Turning Point Learning Center Parent Handbook and understand and agree to abide by the policies and procedures set forth in this document.

_____	_____	_____
Child's Name	**Parent's Signature**	**Date**

_____	_____
Director's Signature	**Date**