



2021-2022 School Year

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

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
- _____ Sunscreen (**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 special 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