



## Smart Start Learning Academy Application

Please include a \$25 non-refundable deposit with your application. Thank you.

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Child's Last Name	First Name	Middle Name
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Date of Birth	Age	Gender
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**Family Information:**

Parent #1:

Name:

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Address:

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Phone (home):

Phone (work):

Phone (cell):

E-mail address:

Occupation:

Please put a star next to the  
phone number we should call  
first.



## Smart Start Learning Academy Application

Parent #2:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Phone (cell): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Please put a star next to the  
phone number we should call  
first.

### **Additional Authorization for Child Pickup:**

Name: \_\_\_\_\_  
\_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Phone (cell): \_\_\_\_\_

Name: \_\_\_\_\_  
\_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Phone (cell): \_\_\_\_\_



## Smart Start Learning Academy Application

### **Additional Authorization for Child Pickup:**

Name: \_\_\_\_\_

Phone (home): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Phone (cell): \_\_\_\_\_

E-mail address: \_\_\_\_\_

### **Enrollment:**

**Circle the days you would like to enroll your child at Smart Start**

Monday   Tuesday   Wednesday   Thursday   Friday

### **Parent Statement:**

1. Why would you like your child to attend Smart Start Learning Academy?



## Smart Start Learning Academy

### Application

2. What goals do you have for your child's education?
  
  
  
  
  
  
  
  
  
  
3. Please describe your child's strengths and challenges.
  
  
  
  
  
  
  
  
  
  
4. Please describe your child's special interests, talents, and/or other unique qualities.
  
  
  
  
  
  
  
  
  
  
5. Does your child have any special needs (academic, physical, etc.?) If yes, please explain in detail, and if there are any accommodations your child requires. (use back page for in-depth detail)



## Smart Start Learning Academy

### Application

6. How did you learn about Smart Start Learning Academy?

#### Permission to Photograph:

My child \_\_\_\_\_ has permission to be photographed for school projects, and in some classes marketing. Safety is always a concern, therefore we assure you that images will be respectful, appropriate, and related to education.      **YES**              **NO**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

#### Parent/Guardian Declaration:

The information contained in this application is full and complete to the best of my knowledge. I agree to support the school and understand that my participation is essential to a successful educational experience.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

# Medical Form

## Basic Information

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child lives with: ☐ Mother ☐ Father ☐ Other: \_\_\_\_\_

Other children living with child:

1. Name _____	Age _____	Sex _____
2. Name _____	Age _____	Sex _____
3. Name _____	Age _____	Sex _____

## Health History

1. Any illness child has had or has? (Asthma, Chicken Pox, Diabetes, Epilepsy, Measles, Mumps, Pneumonia, Strep Throat, Whooping Cough or Other) \_\_\_\_\_

2. Allergies? (Food, drug, bee stings, etc.)

TYPE	SYMPTOMS	TREATMENT

3. Immunization – A copy of the immunization record needs to be attached and signed by the doctor.

4. Does your child have a condition that, according to current medical information, would pose a direct threat to the safety of the others in the program? ☐ Yes ☐ No

5. Does your child have any special needs that require accommodation by the provider?

☐ Yes \_\_\_\_\_ ☐ No

Please list accommodation

6. Does your child have any functional limitations? (Functional limitations can include, but may not be limited to, limitations dealing with hearing, seeing, breathing, speaking, learning, working, performing manual tasks, caring for oneself, social skills, and behavioral actions.) If so, please list: \_\_\_\_\_

## Developmental Background

Name of previous childcare programs attended: \_\_\_\_\_

Does the child have any special problems/fears? \_\_\_\_\_

Child's favorite foods, activities? \_\_\_\_\_

Child's nap pattern: \_\_\_\_\_

Child's favorite toy or blanket: \_\_\_\_\_



Toilet habits: \_\_\_\_\_

Child's eating habits: \_\_\_\_\_

What makes the child frustrated or upset? \_\_\_\_\_

Family rules that provider should know about: \_\_\_\_\_

What methods of discipline do you find works best for your child? \_\_\_\_\_

### Medical Emergency Consent

Name of Child's physician or health clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Child's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

When there is a medical emergency, or when a child needs immediate medical treatment, the provider will take all reasonable steps to see that the children in her care receive adequate medical care. When appropriate, the provider will call 911 and the parent(s). If the parent(s) cannot be reach, the provider will call the person(s) listed below who are authorized by the parent to give permission for the medical treatment of the child. These persOn(s) authorized to do so are:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If the parent(s) and the authorized person(s) cannot be reached, the provider will call the child's doctor, identified above. the child must be taken to the hospital, the provider will take the child to the child's hospital identified above. If under the circumstances, it is more reasonable to bring the child to another hospital, the provider will do so. In the situation where the parents(s) and the person(s) authorized to give permission for medical treatment are not able to be reach, the parent authorizes the child's doctor to provide the appropriate medical treatment for the child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Medical Release Form

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In the event of an emergency, please call in the order indicated (1,2,3,4,5) the following people:

1. Mother: Name and Phone \_\_\_\_\_
2. Father: Name and Phone \_\_\_\_\_
3. Relative: Name and Phone \_\_\_\_\_
4. Doctor: Name and Phone \_\_\_\_\_
5. Friend: Name and Phone \_\_\_\_\_

In the event that none of the above people can be reached, I hereby give my consent to : \_\_\_\_\_ to administer or call for emergency care for my child under extreme conditions. I expect that a conscientious effort will be made to locate me or one of the above designates before any action is taken. If it is not possible to locate me or any of the above designates, any expenses incurred will be paid by me.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date