

**Clark County Association for Handicapped Citizens
Early Learning Center
PO Box 643
Winchester, KY 40392
859-744-3183
Fax - 859-744-4403**

**BEFORE YOUR CHILD CAN ATTEND CCAHC'S EARLY LEARNING CENTER,
WE MUST HAVE THE FOLLOWING INFORMATION**

(REQUIREMENTS)

- _____ Application for Admission
- _____ Birth Certificate full size copy from the bureau of Vital Statistics in Frankfort.
- _____ Immunization Certificate
- _____ Copy of his / her Social Security Card
- _____ Proof of Income such as a check stub, W-2 or tax return
- _____ Copy of Medical Insurance Card
- _____ Food Program Form
- _____ Door Access Code Form
- _____ \$25 Enrollment Fee (checks payable to CCELC)

(CONSENT)

- _____ Emergency Treatment for Child Consent
- _____ Child Release / Emergency Contacts Form

(CONSENT)

- _____ Parent Agreement
- _____ Permission for Picture Use Form

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Child Release/ Emergency Contacts Form

I hereby authorize my child _____ to be released **ONLY** to the following people. The authorized person must sign the Child Sign Out Form and show picture identification before taking my child. I also authorize the CCAHC Staff to contact the following people in case of emergency or illness. **PARENTS PLEASE MAKE SURE TO PUT YOUR NAMES ON THIS LIST.**

Name

Relationship to the child

Address

Phone

Name

Relationship to the child

Address

Phone

Name

Relationship to the child

Address

Phone

Name

Relationship to the child

Address

Phone

Name

Relationship to the child

Address

Phone

Name

Relationship to the child

Address

Phone

I understand that I must meet with the staff and complete a new form should there be any changes in the status of the above information.

Parent signature

Date

Witness Signature

Date

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Emergency Treatment for Child Consent

Only parent or legal guardian can authorize emergency medical treatment

I understand that in the event of an accidental swallowing of poisonous substances the staff will call the Poison Control Center.

In the event that I (parent or legal guardian) am unavailable, I hereby give my written consent for services to be rendered for emergency medical care that is deemed appropriate until I (parent or guardian) can be contacted.

Name of Child _____ DOB _____

Allergies _____

Attach doctor documentation

Special Medical Problems _____

Date of late DPT Shot _____

Names of Parent/ Legal Guardian _____

Home Phone _____ Work Phone _____ cell phone _____

Place of Employment/ School _____

Names of Parent/ Legal Guardian _____

Home Phone _____ Work Phone _____ cell phone _____

Place of Employment/ School _____

Other Contacts _____ Relationship: _____ phone _____

Other Contacts _____ Relationship: _____ phone _____

Name of Physician _____ phone _____

Insurance Company _____

Signature _____ Date _____

Witness _____ Date _____

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Child Information

Childs Legal Name:

Last: _____ First _____

Preferred name: _____ SSN# _____

Date Of Birth _____ Race _____ Sex _____

Family Information

Primary Adult: _____ SSN # _____

Family Name _____ Number in Family _____

Number in Household _____ Number of Children _____

Parent/ Guardian _____ Address _____

City _____ State _____ Zip _____

Phone _____ Work _____ Cell _____

Email _____

Does the child have a disability or special need? Yes No Mark yes only if written documentation is provided.

Family Member Information

First and last name of adults	Adults		Sex	Employment
	DOB	Social Security Number		
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Children

First and last name of Children	DOB	Social Security Number	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Pictures And Video

Child's Name: _____

I grant my permission for the following:

____ Using my child's pictures or video and name in relation to the program activities.

____ Using my child's picture or video and name in relation to program activities for publicity purposes.

____ Using the child's pictures and video for training purpose. (The child's name will not be used for this purpose.)

____ I do **Not** Grant permission for my child's picture or video to be taken.

Signature of Parent or Guardian _____

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Parent Daily Schedule Agreement

Provided by Parent/ Family Member Or Other Adult

Childs Name _____

Typical time of Arrival at the Center _____

Typical time of Departure _____

1. I or an authorized person will transport my child to and from the center at the Designated time each day the center has classes
2. I shall call the center and leave a message if my child is sick or is not going to Attend for any reason.
3. I or an authorized person will take my child into the classroom and pick my child up.
4. If school is dismissed early because of weather, power outages, or problems with The building the center will try to contact me or an authorized person to come pick up my child.
5. I understand that I will be responsible for my child not bringing toys, gum, candy, food, or medicine into the classroom.
6. I understand that persons I have authorized on the Child Release Form may be required to provide a photo ID before my child will be released.

Parent / Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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We are sometimes asked if we need anything for our classroom. Below is a list of items we use on a regular basis. If you would like to contribute any of these we would greatly appreciate it.

Batteries – All Sizes
Kleenex
Ziploc Bags
Paper Towels
Paper Plates – Plain white any size
Children's Socks

Crackers for snacks:

Goldfish
Pretzels
Cheese Nips
Ritz
Saltines

Thanks,

Early Learning Center Staff

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Child's Name _____

I have received the Early Learning Center Handbook. I will read it and ask questions about anything I do not understand.

I agree to sign the Child Sign IN / OUT record when bringing my child to school or picking up my child before the school day is over. I agree that any authorized person who brings my child to school or picks up my child will provide a photo ID.

I agree to keep my child's shot records up to date.

I agree to contact the center when my child is ill or will not be in attendance. I understand that a doctor's statement may be required (Refer to the Health Section of the Parent Handbook).

I agree that if my child gets sick on the bus or at school, that my representative or I will be called to pick up my child.

I agree to notify my child's teacher if my child is taking medication of any kind.

I agree not to send medication of any kind to the school with my child. In the event my child needs any medication during class time I will bring it in with the doctor's instructions in a separate labeled container.

I agree to pay my expenses in a timely manner. I further understand that I am responsible to pay for the times my child may miss due to being sick or on vacation.

I agree to send a backpack to school with my child containing extra clothes, diapers (if needed) and coat and a jacket as needed by the weather.

I agree that my child may go outside or on walking field trips daily, (weather permitting)

Signature _____ Date _____

CLARK COUNTY EARLY LEARNING CENTER DOOR ACCESS CODE

CHILD'S NAME: _____

PARENT'S NAME: _____

4 DIGIT CODE: _____

** WE RECOMMEND THAT THE CODE BE THE LAST FOUR
DIGITS OF EITHER PARENT'S SOCIAL SECURITY NUMBER.

I UNDERSTAND THAT THIS CODE GIVES ACCESS TO ANYONE
WHO HAS IT. IN MAINTAINING SAFETY, I AGREE TO DISTRIBUTE
THE CODE ONLY TO PERSONS TO WHOM I GRANT
UNCONDITIONAL ACCESS TO MY CHILD.

X _____

PARENT SIGNATURE