



**SL Ministries**  
*The Academy for Learning  
and Character Development*

3807 Telstar Circle  
Huntsville, Alabama 35805  
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# STUDENT

  

# Registration

  

# Packet

# Notes and Comments

## EMERGENCY CONTACTS

Please list name of friend or relative to be contacted in case of emergency if parents cannot be reached.



Name and relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name and relationship \_\_\_\_\_ Phone \_\_\_\_\_

## AUTHORIZED TO PICK UP CHILD

The following people, are authorized to pick up my child.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Identification \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Identification \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FORM OF AFFIDAVIT for Parent/Guardian**

**STATE OF ALABAMA  
COUNTY OF MADISON**

Before me, a notary public in and for said state and county, appeared

\_\_\_\_\_ and is known to me, after being duly sworn or affirmed, says as follows:

That affiant is the parent or legal guardian of the minor child/children

\_\_\_\_\_ that affiant has been notified by **Jerome Collins** a representative of **The Academy for Learning and Character Development church/school**, that said church or school has filed notice and is exempt under law from regulation by the department of human resources.

\_\_\_\_\_ Parent/Legal Guardian

Sworn, or affirmed to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:  
-

# REGISTRATION

## STATEMENT OF STANDARD, POLICIES and AUTHORIZATION FOR THE RELEASE OF INFORMATION

The Academy for Learning and Character Development (ALCD) charges a registration fee of [REDACTED] per year. I understand that this fee is due at the time of registration. If the fee is not paid at that time of registration a [REDACTED] late payment fee will be assessed. I/WE authorize ALCD to obtain information about me or my family that is pertinent for collections of outstanding debts incurred with the daycare. Inquiries may be made about (but not limited to): Child Care Expenses; Credit History; Federal, State, Tribal, or Local Benefits; Employment, Income, Pension and Asset; Identity and Marital Status; Residences. Any Individual or organization including any governmental organization may be asked to release information. For example, information may be requested from: Banks and other Financial Institutions; Courts; Law Enforcement. Agencies; Credit Bureaus; Employers, past and present; Schools and Colleges; U. S. Social Security Administration; U.S. Department of Veterans Affairs; US Department Housing and Urban Development (HUD); Utility Companies; Welfare Agencies. I/We agree that photocopies of this authorization may be used for the purposes stated above. If I do not sign this authorization, I also understand that my child's enrollment may be denied or terminated. And any legal action to enforce the terms hereof or relating to the enrollment fees, regardless of the outcome, The Academy for Learning and Character Development or agent shall be entitled to all costs Incurred in connection with such action, including but not limited to attorney's fee. Parent/guardian acknowledges all legal and attorneys' fees shall be classified and billed to as "added fees."

Date Fee paid \_\_\_\_\_ Amount. Paid: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

This statement is to verify that \_\_\_\_\_ parent(s)/guardian(s)  
of \_\_\_\_\_ has received a copy and read the Parent. Handbook.

My signature above indicates my agreement to comply with the stated terms and conditions.

# NEW CLIENT ENROLLMENT

Enroll Date \_\_\_\_\_

Child's Age \_\_\_\_\_

Contact Phone# Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Child's Name: (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Child's Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_



Mother's Name: (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_

Employment \_\_\_\_\_ Address \_\_\_\_\_

Monthly Income: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_

Father's Name: (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_

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

Monthly Income: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_

# GENERAL INFORMATION

Name \_\_\_\_\_  
First Last Middle

Previous Child care \_\_\_\_\_ Phone \_\_\_\_\_

Unusual eating habits \_\_\_\_\_  
\_\_\_\_\_

Sleeping habits \_\_\_\_\_  
\_\_\_\_\_

Known Phobias? \_\_\_\_\_  
\_\_\_\_\_

Particular strong likes and dislikes \_\_\_\_\_  
\_\_\_\_\_

Known food allergies \_\_\_\_\_  
\_\_\_\_\_

Behavioral problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Toilet trained?  Yes  No

Additional comments \_\_\_\_\_  
\_\_\_\_\_

Is English the child's primary language? \_\_\_\_\_  
\_\_\_\_\_

Any custody issues we should be aware of? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personal references Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_

Credit references Name \_\_\_\_\_  
Name \_\_\_\_\_

# MEDICAL INFORMATION

Phone \_\_\_\_\_

Name \_\_\_\_\_  
First Last Middle

Doctor \_\_\_\_\_ Dentist \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

## ILLNESSES



Please mark if your child has had any of the following

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Measles   |
| <input type="checkbox"/> Bee allergies | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps     |
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> HIV            | <input type="checkbox"/> Rubella   |

Other... \_\_\_\_\_

The following are physical conditions or illnesses that could effect my child's play while in your care.

Examples: allergies, ear tubes, heart problems, etc...

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Insured \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Company and Policy #

Facility/Provider \_\_\_\_\_

## PERMISSION IS GIVEN TO THE CHILD CARE FACILITY FOR THE FOLLOWING

Mark appropriate box

- Provider/facility may call an ambulance if necessary
- Provider/facility may take my child to physician or hospital
- My child may be given medication prescribed by the child's physician
- My child may be given non-prescribed medication as requested by parent

I understand that any expenses are my responsibility.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# EMERGENCY MEDICAL

Child's Name _____		
First	Last	Middle
Child's Doctor	_____	Phone _____
Child's Dentist	_____	Phone _____
Name of Insured	_____	
Medical Insurance	_____	
	Company and Policy #	
Mother	_____	_____
	Home Phone	Work Phone
Father	_____	_____
	Home Phone	Work Phone

Either parent, or a guardian, having legal custody of a minor may give written authorization for an adult into whose care the minor has been entrusted to consent to x-ray examinations, anesthesia, medical or surgical diagnosis, and/or treatment and hospital care to be rendered to said minor under the general or special supervision and advice of a physician and surgeon licensed under the provisions of the medicine Practice Act, or to X-ray examinations, anesthesia, dental and/or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

I \_\_\_\_\_ and or \_\_\_\_\_

understand the above and hereby authorize \_\_\_\_\_

to give permission for any necessary medical, hospital, or dental treatment for my child

\_\_\_\_\_ in the event of injury or illness,

while the child is in the care of the above named facility or provider. I understand and agree

that I am financially responsible for any such expenses.

I understand that any attempt to contact the parent/guardian will be made first. (Providing a life threatening situation does not allow time without jeopardizing the child's life.)

Signature \_\_\_\_\_

Date \_\_\_\_\_



# PARENT FEE AGREEMENT

Name \_\_\_\_\_  
          First                                Last                                Middle

I \_\_\_\_\_ and/or \_\_\_\_\_

Agree to pay The Academy for Learning and Character Development \$\_\_\_\_\_ per \_\_\_\_\_

Payment due date(s) Fridays in advance

If my payment goes beyond this date, I agree to pay \$10.00 each week payment is not made.

I understand and agree to pay an additional overtime charge of **\$5.00** per hour,

**in the event the child/children are cared for at times beyond those stated below.**

Delinquent Accounts which require legal action for collection will incur an interest expense of 8% per annum starting on the delinquent date, In addition to attorney and collection fees incurred in accordance with Alabama State Law.

## CHILD CARE SCHEDULE

Days of the week \_\_\_\_\_

Hours of the day \_\_\_\_\_



A \$35.00 fee will be charged for returned checks, no exceptions.

I agree to give 14 days notice should I decide to discontinue child care services.

## ADDITIONAL TERMS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand all of the above and agree to the terms:

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

PHOTO/TRANSPORTATION/VOLUNTEER FORM

Name \_\_\_\_\_  
First Last Middle

please mark appropriate box

I give the following  I do not give the following

facility/provider \_\_\_\_\_ permission to take or have taken photo's  
please mark appropriate box

of my child should the occasion arise.  I give permission  do not give permission for my child to be video taped. I understand these photo's will not be sold or distributed without my knowledge or permission.

**Photo's may be taken on special occasions, new arrivals, arts & crafts, projects, etc...**

please mark appropriate box

I give the following  I do not give the following

facility/provider \_\_\_\_\_ permission for my child to be transported at times other than arranged prior field trips in the event there is a medical emergency I give permission for my child to have any medical treatment necessary.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

PARENT VOLUNTEER FORM

Parents are asked to volunteer twelve hours per year.  
Volunteerism by in the form of:

- \_\_\_\_\_ Attending field trips
- \_\_\_\_\_ Assisting with special programs
- \_\_\_\_\_ Repair/cleaning toys
- \_\_\_\_\_ Advertising
- \_\_\_\_\_ Sitting with students during nap time (12-2) for teachers to attend training
- \_\_\_\_\_ Serve on the Parent-Teacher Council
- \_\_\_\_\_ Fundraising
- \_\_\_\_\_ Making photo copies

Indicate any other assistance that you would like to provide: