KALEIDOSCOPE OF LEARNING AFTER SCHOOL GYMNASIUM
2022-2023 School Age Child Care
Enrollment Form

Grade ___________ Today's Date ______________________ Preferred Start Date_______________

Child's Full Legal Name ____

Address____

City ____________________________ State ____________________ Zip Code __________________

Child's Gender: ___M ___F Date of Birth __________ Last School Attended ________________

Parents automatically on Authorized Pick-Up if listed.	Mother's Information/Authorized Pick-Up	Father's Information/Authorized Pick-Up
Name		
Email Address		
Home Phone		
Cell Phone Number		
Cell Phone Carrier		
Work Phone		
Place of Employment		
Work Address		

Emergency Pick-Up (other than parents)			
	Name	Relationship	Phone
Contact 1			
Contact 2			
Doctor			

Authorized Pick-Up (other than parents and emergency pick up)			
	Name	Relationship	Phone
1			
2			
3			
4			

Hours of Service Needed during Summer Camp: Drop off ______am Pickup ____pm

Does your child have any special health problems or reactions? _____ Asthma _____ Allergies

If other problems or reactions, please explain ____

Does your child have reactions to _______ Food _______ Medicine _______ Insect Bites

What subject area those your child needs additional help? ____________________________________

Does your child have any known behavior problems? ____

Does your child have any special needs or disabilities? _______________________________________

Please read carefully and check the appropriate areas.

1. **I give permission for the child listed on this application to be photographed or videotaped while in attendance at this center during center activities.**

   ______My child may be photographed _____My child may not be photographed

2. **I give permission for the child listed on this application to be transported by Kaleidoscope of Learning while in attendance at this center during an emergency, center activities or after school pick up.**

   ______My child may be transported _____My child may not be transported

3. **I have received a copy of the Mississippi State Department of Health Regulation Summary for Parents.**

   ______I did receive a copy ______I did not receive a copy

4. **Kaleidoscope of Learning has the authority to obtain emergency medical treatment for my child in case of emergency.**

   ______My child may receive treatment ______My child may not receive treatment

5. **My child will eat ____breakfast ____lunch _____snack at the center. (Please check)**

Parent's Signature ____ Date________________

PLEASE SELECT ONE.			
Afterschool Traditional $135/$270 month	Select Hours: □ **(3pm-6pm)**		
Afterschool Traditional-Summer/Holidays Full Day Hours-$250/$500 month	Select Hours: □ **(7am-4pm)**	□ **(7:30-4:30pm)**	□ **(8:00am-5:00pm)**

FOR OFFICE USE ONLY: Date of Acceptance (start date) ___________________

Certification of Immunization Form 121 – Date received ____________________________________

Date of Withdrawal ______ Reason for Withdrawal ____

KOL Staff Signature ___________________________________ Date___________________________