KALEIDOSCOPE OF LEARNING AFTER SCHOOL GYMNASIUM
2024-2025 School Age Childcare
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			

337 Byram Drive
Byram, Mississippi 39272
601-502-2989
2/1/24

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 $150/$300 month	Select Hours: ☐ **(3pm-6pm)**		
Afterschool Traditional-Summer/Holidays Full Day Hours-$260/$520 month	Select Hours: ☐ **(7am-4pm)**	☐ **(7:30-4:30pm)**	☐ **(8:00am-5:00pm)**
Days of Service Needed	Select Days: ☐ **(M-F)**	Select Days: ☐ Drop-In	Select Days Other: ☐

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_____

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