

# New Dimensions, Inc

8733 Tara Blvd  
Jonesboro, Georgia 30236  
Office Number: 770-210-6261  
Fax Number: 770-210-5152



“Soaring to Higher Heights and Into A New Dimension”

We provide quality service to ages 12 months to 12 years.  
Our Hours of Operation are from 5:30a.m. until 6:30 p.m.

## Registration Checklist

- Completed Enrollment Application
- Notarized Emergency Treatment Consent Form
- Georgia Immunization Certificate (3231)
- Birth Certificate
- \$50 Registration Fee
- A copy of Childcare Assistance Forms (if applicable)
- Verification of Guardianship (if applicable)

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**“Soaring Into Higher Heights and Into New Dimensions”**

## Enrollment Application

General Information: Please notify New Dimensions, Inc. of any changes.

Entrance Date: \_\_\_\_\_

Withdrawal: \_\_\_\_\_

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Child's Name	Age	Date of Birth	Sex
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Child's Name	Age	Date of Birth	Sex
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Child's Name	Age	Date of Birth	Sex
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Who does the child live with? \_\_\_\_\_

Marital Status: ( )Married ( )Single ( )Separated ( )Divorced ( )Widowed

If divorced, who has custody of the child? \_\_\_\_\_

### Father's Information

### Mother's Information

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

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

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

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

Home Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

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

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

Work Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Hours of Employment: \_\_\_\_\_

Hours of Employment: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

New Dimensions Academy, Inc.

8733 Tara Blvd Jonesboro, Georgia 30236 770-210-6261

1. New Dimensions Academy, Inc. agrees to provide childcare for \_\_\_\_\_ and \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_.

2. The child(ren) may be released to the persons signing this agreement or to the following:

Name	Address	Phone/Relationships
_____	_____	_____
_____	_____	_____

3. Emergency contact when parents cannot be reached:

Name	Address	Phone/Relationships
_____	_____	_____
_____	_____	_____

4. Physician to be contacted when parents cannot be reached:

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

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

5. I agree to provide evidence of age appropriate immunizations or a signed affidavit against such immunizations. This record will be maintained on each child enrolled in the center and must be updated during the remainder of the child's care.

6. If the child is out of the center for more than two weeks consecutively without prior notice, they must re-register.

7. The weekly fee paid is for 9-½ hours/day. No child will be permitted to stay more than 9 ½ hours/day nor will they be able to stay past 6:30 p.m. If they are here past the allotted time, there will be an additional charge of \$1.00/minute/child payable upon pick-up. It is very important that you pick your child up on time. No Exceptions!!

8. I understand that even if I have childcare assistance, I am solely responsible for the tuition in the event that the assistance is not paid for whatever reason.

9. I understand that New Dimensions Academy Inc, do not carry balances. Your child is not able to enter the center if balance is not paid.

10. If you want your children to eat breakfast here, we ask that you have your child(ren) here by 8:30 a.m.

11. Children will not be allowed to leave with anyone except the parent(s) or persons designated by the parents to pick them up. Photo I.D. must be shown if not parent.
12. In case of violent storms, etc. we understand the parents' concerns, but it is requested that you do not call. PLEASE! It is important for all available staff be available to care for your children.
13. Each child must have a change of clothing that is left in the center and is to be used for emergencies. All clothing must be marked with the child(ren)'s name(s).
14. I agree to pay a total weekly fee of \$\_\_\_\_\_ on Friday prior to the upcoming week. If I do not, I understand there will be an additional charge of \$25.00.
15. I agree to provide the center with all necessary information pertaining to administering medicine to my child(ren) such as date, full name of child, name of medication, prescription number (if any), dosage, dates and times to be given and signature of the parent. If you do not provide us with the necessary information, we cannot administer the medicine to your child(ren).
16. I understand that if a medicine is prescribed to someone else, the center cannot administer the medication to another person.
17. I understand that I must provide a dispenser or measuring cup for the center to use for dispensing my child's medication. If I do not, I understand that the center cannot administer the medication to your child(ren).
18. New Dimension Academy, Inc. agree to administer medication and will record any noticeable adverse reactions of prescribed medications on a authorization of medication form, in detail. The center will attempt to contact the parents if signs of any adverse reaction occur.
19. I understand that my child(ren) will be served lunch and a snack during their hours of attendance. In order for my child to receive breakfast, I must have my child(ren) in the center at 8:30 a.m. In order for my child(ren) to receive lunch, I must have my child(ren) in the center at 10:30 a.m.
20. I understand that according to state regulations, it is my responsibility to either escort my child(ren) in or out of the center or see that a staff member escorts them in and out.
21. If my child(ren) wear diapers, I understand that I will provide whatever disposable diapers that are necessary for my child(ren).
22. I understand that I am totally responsible for any special diet required by my child(ren).

23. I understand that New Dimensions Academy, Inc. does not accept children that are on the bottle. We do accept sippy-cups. The sippy-cups must be labeled with child's name and dates as per state regulations.
24. Transportation is provided to and from the following schools: Brown Elem., Suder Elem., Lee Street Elem., Pointe South Elem., Swint Elem., Pointe South Middle and Mundy's Mill Middle. Transportation is also provided for planned field trips. A separate form and signature is required for field trips and a school transportation form can be signed once for each school year. A field trip form must be signed before each trip.
25. If children are school age, what school do they attend? \_\_\_\_\_
26. Should my child(ren) become ill during the time that he/she is in the care of New Dimensions Academy, Inc. or suffer an accident of any nature, the center shall undertake to contact me immediately and shall be authorized to secure such medical attention and care for my child(ren) as may be necessary. (The parent shall assume responsibility for payment.) I agree to keep the center informed as to changes in telephone numbers, etc. where I may be reached.
27. I understand that if my child(ren) is ill, including, but not limited to severe cough, sore throat, undetermined rash or spots, temperature of 101 degrees, severe headaches, upset stomach or diarrhea he/she may not be accepted into the center until well. In the event that my child has a communicable disease, a release from a medical source may be required before my child(ren) re-enters the center. New Dimensions Academy, Inc. will notify parents if a communicable disease has been introduced into the center.
28. Transportation will also be provided for emergency care. Southern Regional has agreed to provide emergency care. In the event of extreme emergencies or emergencies requiring an ambulance, 911 will be called. These are the only areas in which transportation will be provided.
29. No corporal punishment is instituted at all.
30. New Dimensions Academy, Inc. believes in providing positive discipline in order to teach children how to behave appropriately and build self-esteem. In cases where showing love and providing hugs does not work, time-out (one-minute per child's age) will be instituted to give the child a few minutes from the area or activity so that he/she may gain self-control.
31. If your child shows signs of a communicable disease as stated on the communicable disease chart, he/she will be excluded from the center as per recommendations for the exclusion of sick children and their readmission.

32. New Dimensions Academy, Inc. will provide protection of children in the event of severe weather, fire or physical plant problems (such as power failure). Emergency plans have been developed and posted for parents' viewing.

33. New Dimensions Academy, Inc. reserve the right to release any child from our program whom we feel is not adjusting without any liabilities.

I agree to abide by all the policies and procedures of New Dimensions Academy, Inc. as outlined in this agreement. I have read and understand the above statements. I agree to notify New Dimensions Academy, Inc. of any changes in enrollment information.

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Signature

Date



## External Preparations Form

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

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

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

I hereby give New Dimensions Academy permission to apply one or more of the following external preparations, in accordance with directions for use on the container.

- |  |   |
|--|---|
| <input type="checkbox"/> Baby Wipes                                | <input type="checkbox"/> Sunscreen  |
| <input type="checkbox"/> Band-Aids                                 | <input type="checkbox"/> Insect Repellant   |
| <input type="checkbox"/> Neosporin, Bacitricin or similar ointment | <input type="checkbox"/> Non Prescription ointment (such as A&D, Desitin, and Vaseline) |
| <input type="checkbox"/> Bactine or similar first aid spray        |   |

I release New Dimensions Academy from any liability for administering these preparations.

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Signature

Date

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Signature

Date



# Health Record

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

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

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

Child's Physician or Clinic's Name (Child's Primary Health Source):

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

Physician's Address: \_\_\_\_\_

Does the child have allergies or any other physical problems, mental health disorders, mental retardation or developmental disabilities, which would limit the child's participation in the center's programs and activities?  Yes  No

Specify: \_\_\_\_\_



## Emergency Medical Permission Form

I, \_\_\_\_\_, give permission for New Dimensions Academy to seek medical attention for my child, \_\_\_\_\_ and \_\_\_\_\_ in the event of an emergency if I cannot be reached and to hold blameless and release New Dimensions Academy from all liability. I further agree to keep the center informed of changes in telephone numbers, etc. where I can be reached. \_\_\_\_\_

Parent's Signature

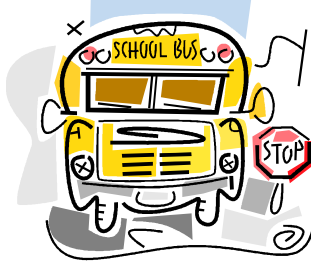
Date

New Dimensions Academy emergency medical procedures will be as follows:

1. Contact parent
2. Contact persons listed as emergency contact
3. Call emergency medical team, if necessary
4. Have Emergency Medical Team transport to the nearest hospital
5. We will seek medical attention from: Physician \_\_\_\_\_

Hospital \_\_\_\_\_ Medical Group \_\_\_\_\_

# Vehicle Emergency Medical Information Form



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Child's Name

Birth Date

Child's Name

Birth Date

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Address

---

Father's Name

Home Phone

Work Phone

Cell Phone

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Mother's Name

Home Phone

Work Phone

Cell Phone

In case of emergency and parents cannot be reached, contact:

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Name

Phone

Physician's Name

Phone

Medical Facility that the center uses: Southern Regional Medical Center 11SW Upper Riverdale Rd.

Child's Allergies: \_\_\_\_\_ Current Prescribed Medication: \_\_\_\_\_

Child's Special Medical Needs and Conditions: \_\_\_\_\_

In the event of an emergency involving my child and New Dimensions Academy cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child and to hold blameless and release New Dimensions Academy from all liability.

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Parent/Guardian

Date

Witnessed By

Date

## Medical Care and Emergency Contact Information

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

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

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternate Emergency Contact Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_ Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's Known Allergies (medicine, food, etc.) \_\_\_\_\_

Describe past serious illnesses or hospitalization, with dates: \_\_\_\_\_

Medicines taken by child: \_\_\_\_\_ Date of last tetanus injection: \_\_\_\_\_

Describe all physical conditions or illnesses which could affect the child's participation in the program or the proper treatment (diabetes, epilepsy, poor blood clotting, etc.) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Emergency Medical Treatment Consent

I hereby give New Dimensions Academy permission to provide first aid care for my child, \_\_\_\_\_ . In the event I cannot be reached, I hereby authorize New Dimensions Academy to transport my child to and be cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

\_\_\_\_\_ Hospital \_\_\_\_\_

( ) Nearest Hospital \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

The foregoing consent was acknowledged before me on this \_\_\_\_\_ day of \_\_\_\_\_ by \_\_\_\_\_

\_\_\_\_\_

(Notary Seal)

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

My Commission Expires \_\_\_\_\_