



# Children's Collaborative

[www.Childrenscollaborative.org](http://www.Childrenscollaborative.org)

Children's Collaborative is an independent sub-contractor to the Campbell Co. Schools,

## REGISTRATION FORM (2021-2022)

Child's name \_\_\_\_\_ Birth date \_\_\_\_\_ age \_\_\_\_\_

Teacher's Name & Classroom \_\_\_\_\_ Gender **M** or **F**

Nick name or name child is most often called \_\_\_\_\_

Child's home address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (zip) \_\_\_\_\_

Date child will start the Collaborative program \_\_\_\_\_

If your child's schedule changes please contact 859-653-2520 immediately, **ADDITIONAL CHARGES MAY BE APPLIED IF NOT PROPERLY NOTIFIED OF SCHEDULE CHANGES.**

Mother's Name \_\_\_\_\_

Father's name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_

Home phone \_\_\_\_\_

Cell \_\_\_\_\_

Cell \_\_\_\_\_

Work \_\_\_\_\_

Work \_\_\_\_\_

Drivers License # \_\_\_\_\_

Drivers License # \_\_\_\_\_

Place of employment \_\_\_\_\_

Place of employment \_\_\_\_\_

Email address \_\_\_\_\_

Email address \_\_\_\_\_

Parents: married \_\_\_\_\_ together \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ deceased \_\_\_\_\_

List sibling's name and ages \_\_\_\_\_

**Emergency Contacts** and those authorized to release child to from the program: (if more space is needed, please write information on the back.)

(1) Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Home# \_\_\_\_\_

(2) Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Work # \_\_\_\_\_ Cell# \_\_\_\_\_ Home # \_\_\_\_\_

(3) Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Work # \_\_\_\_\_ Cell# \_\_\_\_\_ Home # \_\_\_\_\_

Are you eligible for: Free lunch \_\_\_\_\_ Reduced lunch \_\_\_\_\_

Case / Social worker's name \_\_\_\_\_

Please check all that applies for which you are enrolling your child for

Before school \_\_\_\_\_ Days attending: **M T W T H F**

Campbell Ridge \_\_\_\_\_

After school \_\_\_\_\_ Days attending: **M T W T H F**

Cline Elem \_\_\_\_\_

Crossroads \_\_\_\_\_

Grants Lick \_\_\_\_\_

Inclement weather / days school is not in session \_\_\_\_\_

Reiley Elem \_\_\_\_\_

3 / 4 yr Preschool \_\_\_\_\_

**\*Contact Children's Collaborative at 859-653-2520 with any questions.**

Please send completed form with registration fee to 6699 Alexandria Pike, Alexandria, KY 41001 or fax to 859-635-3803.

The Collaborative operates independently and contracts for services to the Campbell County School Board. Any Questions or concerns shall be addressed to Collaborative Management at 859-653-2520.



# Children's Collaborative

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(Numbers 1, 2, & 3 are required signatures. Number 4 is optional)

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

1. I have received my copy of the Children's Collaborative handbook. The handbook describes the policies and procedures used at the facility. It also outlines my privileges and obligations as a parent. I will read and familiarize myself with the information it provides. Should a question or concern arise, I will contact the director immediately.

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date

2. If Children's Collaborative has planned activities outside the fenced in area (walks, nature hikes, etc...)

\_\_\_\_\_ I will allow my child to play outside the fenced area

\_\_\_\_\_ I will **NOT** allow my child to play outside the fenced in area.

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date

3. I hereby release and hold Children's Collaborative and its employees harmless from any and all claims, damages or other liabilities for loss or damage to any personal articles of my child or any injuries to or damages by my child which are not a result of gross negligence by Children's Collaborative or their employees.

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date

4. I hereby grant Children's Collaborative permission to take photographs of my child for use in classroom activities and to be posted on [www.childrenscollaborative.org](http://www.childrenscollaborative.org) or [www.facebook.com](http://www.facebook.com).

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date

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# Children's Collaborative

\*Children's Collaborative works in cooperation with the school but we are a separate entity.

## Medical History / Medical Authorization

Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

If your child is on medication please list the name(s) and dosage(s), dosage times: \_\_\_\_\_

Medication Name	Dosage	Time(s) administered
Medication Name	Dosage	Time(s) administered

### \*Medical History

CRITICAL INFORMATION TO YOUR CHILD'S SAFETY &

WELLBEING My child has had the following:

High fevers \_\_\_ Seizures \_\_\_ concussion/head injury \_\_\_ Eating disorder \_\_\_  
 Heart disease \_\_\_ Breathing problems \_\_\_ Ear infections \_\_\_ Headaches \_\_\_  
 Broken bones \_\_\_ Thrush \_\_\_ Problems with immunizations \_\_\_

*Please explain and include treatment for the above*

\_\_\_\_\_ My child has an allergy to the following:

Insect bites \_\_\_ Foods \_\_\_ Medications \_\_\_ other \_\_\_

*Please explain and include treatment for the above*

My child has: \* The school does not provide information on a student's IEP or ANY diagnosis. If your child has a need of any kind that requires specific care or attention it is up to, YOU, the PARENT/GUARDIAN TO TELL US! In addition, please provide us with a copy of your child's IEP or diagnosis!!!!\*

Attention Deficit Disorder \_\_\_ Hearing Loss \_\_\_ Speech/language disorder \_\_\_  
 Glaucoma/eye disorder \_\_\_ Motor delays \_\_\_ Social / Emotional issues \_\_\_ Running/Extreme Behavior \_\_\_

**PLEASE EXPLAIN IN DETAIL:**

### \*Medical Authorization

I hereby grant The Children's Collaborative permission to administer or seek emergency medical treatment for my child in my absence. If emergency care is necessary, I give permission for treatment deemed necessary by a physician and/or hospital of your choice, when possible. (Emergency medical team reserves right to choose)

List Hospital here: \_\_\_\_\_

Parent / legal guardian's signature

Date