



Dear Family:

Thank you for your interest in the Elaine Clark Center. I have enclosed our application for enrollment.

In addition to returning the attached enrollment papers, please send copies of other evaluations of your child such as physical therapy, occupational therapy, and speech therapy evaluations. Any other information on your child such as doctor's reports or current IFSP or IEP would be helpful.

Upon receiving your child's application, medical forms, and other pertinent information, an intake meeting will be scheduled so that we may meet with you and your child. When all requested information (specifically the physician report) is made available, your child's services may begin immediately. The Medical Assessment form is to be filled out by your child's doctor. The Immunization Certificate may be filled out by the Health Department or by your child's doctor.

If you have any questions or need additional information, you can contact me at 770-458-3251.

Sincerely,

Leslie White
Social Services Coordinator

Enclosures



IMPORTANT INFORMATION

CENTER HOURS: 7:30 a.m. to 6:00 p.m. Parents picking their children up after 6:00 p.m. will be charged a late fee of \$1.00 per minute.)

ATTENDANCE Each child is allowed sixty excused absences per school year. Our school year begins July 1 and ends June 30. For those children beginning after July 1, the number of allotted absences will be prorated for the number of months the child will attend school during the year. Children must arrive by 10:00 a.m. unless arrangements have been made with the teacher or social services coordinator.

FEES Tuition rates are as follows:

Infant	\$215.00
Toddler	\$205.00
Two Year Old	\$190.00
Three and Four Year Olds	\$180.00
School Age	\$165.00
After School (ages 3-7)*	\$ 95.00
Before and After School	\$115.00
Daily Rate for Children in Before & After School Care**	\$ 20.00
P.L.A.Y. Program	
Tues. & Thurs.	1\$ 50.00
Multi-Child Discount	\$ 25.00 (per family)

Tuition fees must be paid by noon on Wednesday of each week or a \$15.00 late fee will be charged.

A nonrefundable annual registration fee of \$50.00 is due upon application and annually thereafter.

* Transportation is not provided. Hours are 1:30-6:00.

**Daily rates are for children enrolled in the before and/or after school program.



IDENTIFYING INFORMATION

CHILD'S NAME _____ D.O.B. _____

COUNTY of RESIDENCE _____ HOME PHONE # _____

BIRTH PLACE
Hospital _____ City _____ State _____

SERVICE COORDINATOR

Name _____ Phone Number _____

Requested Beginning Date _____

Full Time Program Mother's Morning Out

ATTACH PHOTO _____ MEDICAID # _____

HEALTH INSURANCE CARRIER _____

POLICY NUMBER _____

IS THIS CLIENT COVERED UNDER THIS
POLICY? YES _____ NO _____

LEGAL GUARDIAN _____

RELATIONSHIP TO CHILD _____

ADDRESS _____

CITY _____ STATE _____ COUNTY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

For center use only: Date Received _____

Registration Received Yes No



CHILD INFORMATION SHEET

CHILD'S FULL NAME _____ D.O.B. _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____ RACE _____ SEX ____

IF THIS CHILD IS CURRENTLY IN FOSTER CARE PLEASE COMPLETE THIS PORTION

FOSTER PARENT(S) NAME _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

WORK NUMBER _____ HOME NUMBER _____

CASEWORKER'S NAME _____

COUNTY _____ AGENCY _____

EMERGENCY CONTACTS (Other than Parents)

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

WORK NUMBER _____ HOME NUMBER _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

WORK NUMBER _____ HOME NUMBER _____



PARENT INFORMATION

MOTHER (FULL NAME) _____

HOME ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ OCCUPATION _____

EMPLOYER _____

BUSINESS ADDRESS _____

DATE OF BIRTH _____ MARITAL STATUS M__ S__ D__ W__

FATHER (FULL NAME) _____

HOME ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CELLPHONE _____ OCCUPATION _____

EMPLOYER _____

BUSINESS ADDRESS _____

DATE OF BIRTH _____ MARITAL STATUS M__ S__ D__ W__

BROTHERS AND SISTERS

NAME	D.O.B.	LIVING IN THE HOME

OTHERS LIVING IN THE HOME

NAME	D.O.B.	RELATIONSHIP



MEDICAL AND EDUCATIONAL PROVIDER INFORMATION

PEDIATRICIAN _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____

DEVELOPMENTAL EVALUATION _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____

HOSPITAL _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____

OTHER _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____

OTHER _____

ADDRESS _____

CITY _____ STATE ____ COUNTY _____ ZIP _____

PHONE NUMBER _____



HOW CAN WE HELP?

CHILD'S NAME _____ DATE _____

All children enrolled at The Elaine Clark Center have their own strengths and needs. Please use this form to tell us how we can be most helpful to your family. We know that your needs will change from time to time and that this will just be a beginning point to help us plan together with you. Answer only those questions that you think will help us know how we can be most helpful to you and your family.

1. What pleases you most about your child?

2. What worries you most about your child?

3. What kind of help or information would you like to have from The Elaine Clark Center?

4. Are there things that you feel are going well for your child and your family right now?

5. What would you like to see your child be able to do in the next several months?

6. Please tell us other ways we may be able to help.

7. Tell us about your child when he/she first came home from the hospital.

8. Tell us about your child's development now.

9. Does your child: ___sleep well ___ sleep restlessly ___ hardly sleep

10. Does your child nap? ___ yes ___no

11. Does your child eat well? ___ yes ___no
Does your child have difficulty swallowing? ___ yes ___no

12. Does your child use a cup? ___ yes ___no
Does your child use a spoon? ___ yes ___no
Are there any foods that your child especially likes? _____

Are there any foods that your child dislikes? _____

13. How does your child usually let you know what he/she needs? _____

14. Are there any special things that you have noticed about your child's hearing? _____

15. Are there any special things that you have noticed about your child's vision? _____

16. How does your child respond to strangers? _____

17. How does your child respond to a sitter? _____

18. Does your child like to be held? ____yes ____no

19. Does your child like to be read to? ____yes ____no

20. Does your child like to be with other children? ____yes ____no

21. Is your child presently receiving:

Physical Therapy ____ Where

Occupational Therapy ____ Where

Speech Therapy ____ Where



ALLERGY INFORMATION

CHILD'S NAME _____ D.O.B. _____

PLEASE LIST ALL ALLERGIES KNOWN TO YOU THAT YOUR CHILD HAS. IT IS MANDATORY THAT WE HAVE THIS INFORMATION IN OUR FILES.

FOODS: _____

DRUGS: _____

OTHER : _____

COMMENTS: _____

NOTE: PLEASE PROVIDE A DOCTORS LETTER STATING THAT YOUR CHILD IS NOT TO HAVE THESE FOODS WHILE AT SCHOOL.

DATE

SIGNATURE



THE ELAINE CLARK CENTER PARENT AGREEMENT

CHILD'S NAME _____ DOB _____

1. I/We agree to cooperate with the administration and staff of the Center in every possible way. I/We will see that this child attends the center regularly. I/ We will attend parent conferences, and will attempt to carry through at home the training which is begun at the center.
2. I/We understand that the Elaine Clark Center will provide a program of education and therapeutic play in a loving and safe environment for my child. The Center will provide a nutritional breakfast and lunch for the child, and, if he/she is in attendance at 2:30, the center will also provide an afternoon snack.
3. I/We understand that my child will be going out of doors every day the weather permits and I/We agree to send appropriate outer clothing (coat, hat, boots) to the center every day.
4. I/We agree to release the Center from any responsibility for property damage, illness, accidents, or injury incurred by the child at the Center not due to negligence on the part of the staff personnel.
5. My/Our child's primary care physician is _____, and his/her telephone number is _____.
6. I/We understand that I/We must complete a Permission Form For Medications (Attachment C in the Parent Handbook) before the nurse at the Center will dispense any medication, breathing treatment, tube feeding, or any other medical procedure.
7. I/We agree to show evidence of age appropriate immunizations as needed.
8. My/Our child has the following allergies or limitations which the center should consider in planning his/her inclusion in the Center's meals. program, or activities: _____

9. I/We agree to allow this child to be transported in case of an emergency by ambulance, understanding that this Center will not be responsible for accidents or injury not due to negligence.

10. I/We agree to allow this Center, at the expense of the undersigned, to institute emergency medical treatment through my family physician or other recognized medical resource. When possible, the Center shall contact the undersigned prior to such action.

11. I/We agree to permit the staff of this Center to obtain emergency medical transportation for this child at the expense of the undersigned.
12. I/We understand that I am responsible for keeping the Center advised of any significant changes as the changes occur in the information that I provided at the time of enrollment concerning work locations, emergency contacts, family physician, etc.
13. I/We understand that the Center will not permit my child to enter or exit the Center without an escort.
14. I/We agree to allow this Center to administer any educational assessments needed with the understanding that such information obtained shall be kept strictly confidential and be used in developing an individual education program for this child.
15. I/We agree to permit the use of volunteers and university trainees to work with this child as part of this child's program at the Center. I understand for the volunteers or university students, to provide service to this child, it may be necessary for these volunteers and trainees to have access to this child's records. I further understand that these volunteers and students are instructed in confidentiality.
16. I/We agree to permit this child to be photographed or filmed in conjunction with educational and social activities, as well as for the Center's assistive technology training video which will be marketed nationwide. These photographs and films may be used to publicize and promote the Center.
17. I/We agree with this center's policy of multi-age grouping of the two and three year old students. The ratio in the classroom will remain at the two year old state required ratio, however the educational instruction will be individualized and meet the needs of each child participating in the program.
18. I/We understand that if I/we would like to have our infants mouth swabbed after meals or our child brush his or her own teeth, I/we will provide the center with written permission and a single use only disposable toothette to be used with your child or a toothbrush with sanitary container for storage..

I/We have read and are not in agreement with item(s) _____

Please Explain _____

DATE _____
 This Report is
 CONFIDENTIAL

SIGNATURE _____
 Please Return to:
 The Elaine Clark Center
 5130 Peachtree Industrial Blvd.
 Chamblee, GA 30341



THE ELAINE CLARK VARIETY CENTER
Medical Exam Report

PART I **To Be Completed By Parent(s).**

Last Name _____ First _____ Middle _____

Birthdate _____ Sex _____

Street Address _____ City, State _____ Zip Code _____

Parent's Name _____ Telephone Number _____

PART II **To Be Completed By Physician**

Physical Examination

Height _____ ft. _____ in. Weight _____ lbs. Temperature _____

Pulse _____ Respiration _____ Blood Pressure _____

Laboratory : Serology _____

Check if normal or describe if abnormal:

- | | |
|------------------------|-------------------------|
| 1. Eyes _____ | 10. Hernia _____ |
| 2. Ears _____ | 11. Genitalia _____ |
| 3. Nose _____ | 12. Gynecological _____ |
| 4. Throat & Neck _____ | 13. Ano-Rectal _____ |
| 5. Mouth _____ | 14. Nervous Sys. _____ |
| 6. Breasts _____ | 15. Psychiatric _____ |
| 7. Lungs _____ | 16. Skin _____ |
| 8. Heart _____ | 17. Orthopedic _____ |
| 9. Veins _____ | 18. Abdomen _____ |

Description or comments on above info: _____



PART III

To Be Completed By Physician

Pertinent Medical History

Surgical History

Date

Type

Results

Diagnosis

Prognosis

Current Medication

Allergies

Is child under the care of another physician or health agency?

Are Physical/Occupational/Speech/Feeding evaluation and follow-up services permissible?

_____ *yes*

_____ *no*

Special Instructions regarding: Physical and Occupational Therapy and Feeding:

Limitations on Physical Activity

Contraindications or Precautions

Significant medical implications for this child's education

Additional Recommendations and Comments

Date of Last Visit

Date of Next Visit

I hereby certify that the above named child is under my care and recommend that he/she :
_____ **is** medically stable to participate in the Interactive Sensorimotor Program at the Elaine Clark Center.
_____ **is not** medically stable to participate in the Interactive Sensorimotor Program at the Elaine Clark Center.

Examiner's Name (please print)

Examiner's Signature

Name of Health Clinic or Agency

Street Address

City, State, Zip

Phone Number



Name: _____

Date _____

D.O.B.: _____

Has your child ever tested positive for any of the following?

Hepatitis _____ Type _____

HIV _____

TB _____

If so, medical clearance is necessary for enrollment of this child.

**THIS CHILD IS NOT CONTAGIOUS TO OTHER CHILDREN OR STAFF
AT THE CENTER.**

Doctor's Signature

Date

If the child is contagious, please list all reasonable precautions that should be taken to reduce any risk of contagion.

Doctor's Signature

Date