



Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Mr. Thomas Ford, Executive Director

Registration Requirements

Complete Online Registration @ trytrinityelc.org
Authorization to Dispense External Preparations
Emergency Medical Authorization
Parental Agreement
Vehicle Emergency Medical Information
Income Eligibility
Intake Registry
ProCare Tuition Payment Registry



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Authorization to Dispense External Preparations

I give Trinity AME Early Learning Center, LLC permission to apply one or more of the following topical ointments/preparations/over the counter medications to _____ (Child's Name) in accordance with the directions on the label of the container.

- ___ Baby Wipes
- ___ Band-aids
- ___ Neosporin or Similar Ointment
- ___ Bactine or Similar First Aid Spray
- ___ Insect Repellent
- ___ Non-Prescription Ointment (Such as A&D, Desitin, Vaseline)
- ___ Baby Powder

Other (Please Specify): _____

Signature (Parent/Guardian): _____

Date: _____

* Trinity AME Early Learning Center, LLC will maintain a copy of this for the child's records.



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EMERGENCY MEDICAL AUTHORIZATION

Should (Child's Name) _____ suffer an injury or illness while in the care of (Facility Name) _____ and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian (Print Name): _____

Date: _____

Facility Administrator (Print Name): _____

Date: _____



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Parental Agreement with Trinity AME Early Learning Center, LLC

Trinity AME Early Learning Center agrees to provide care for _____ (Child's Name) on: **Monday, Tuesday, Wednesday, Thursday and Friday**. The care will be provided from _____ A.M. to _____ P.M.

My child will participate in the following meal plan:
Breakfast, Lunch, and an Afternoon Snack.

Before any medication is dispensed to my child, I will provide a written authorization which indicates: dates, name of child, name of medication, prescription number, dosages, and the time the medication should be administered. Medicine must be in the original package with your child's name on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contact, child's physician, child's health status, infant feeding plan and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

Trinity AME Early Learning Center, LLC agrees to obtain written authorization from me before my child participates in routine transportation for field trips/special activities that are away from the facility. Trinity AME Early Learning Center, LLC agrees to obtain written authorization for my child to participate in water-related activities occurring in water that is more than two feet deep.

I authorize Trinity AME Early Learning Center, LLC to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for Trinity AME Early Learning Center, LLC.

I understand that the facility will advise me of my child's progress and issues pertaining to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in activities at Trinity AME Early Learning Center, LLC.

Signature: _____ **Date:** _____
(Parent/Guardian)

Signature: _____ **Date:** _____
(Facility Administrator)



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Vehicle Emergency Medical Information

Child's Name: _____ DOB: _____

Address: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____

Cell Phone: _____ Work Phone: _____

Person to notify in an emergency and parents cannot be reached:

Name: _____ Phone #: _____

Child's Doctor: _____ Phone #: _____

Medical Facility: _____

Address: _____

Child's Allergies: _____

Current Prescribed Medication: _____

Child's Special Needs/Conditions: _____

In the event of an emergency involving my child, and if **Trinity AME Early Learning Center, LLC** cannot get in touch with me, I hereby authorize any needed medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name: _____

Signature (Parent/Guardian): _____

Witnessed By: _____ Date: _____



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