ALL DAY LEARNING CENTERS
170 Township Line Road, Building B
Hillsborough, NJ 08844
908-359-0803

STUDENT ENROLLMENT FORM

Date of Enrollment: _____ Start Date: _____

Child's Name: _____ Sex: _____ D.O.B: _____

Address: _____
Street City State Zip Code

Please check your desired full day schedule

☐ Monday, Wednesday, Friday (Part time)

☐ Tuesday, Thursday (Part time)

☐ Monday, Tuesday, Wednesday, Thursday, Friday (Full Time)

Mother's Name: _____ **Father's** Name: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Occupation: _____ Occupation: _____

Place of Business: _____ Place of Business: _____

Business Phone: _____ Business Phone: _____

Does your child have any siblings? Ages? _____

Is there anything unique or specific you would like for us to know about your child?

_____

_____

Child's Doctor: _____ Phone Number: _____

Does your child have any know medical conditions? If so, please explain below.

_____

Is your child on any medication? Please Describe. _____

Does your child have any allergies? If so, please explain _____

_____

How did you hear about us? _____

Parent/Legal Guardian Signature: _____

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PICK UP AUTHORIZATION FORM

Child's Name: _____

*I authorize the following people, besides myself or other parents, to pick up my child from the center in the event I am not able to do so myself.

First and last name: _____

Relation to child: _____

Phone Number: _____

First and last name: _____

Relation to child: _____

Phone Number: _____

*( ) NO ONE OTHER THAN A PARENT OR GUARDIAN MAY PICK UP MY CHILD

_____ _____

Parent/Guardian Signature Date

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EMERGENCY CONTACT FORM

Child's Name: _____ Date of Birth _____

Mother's Name: _____

Cell Number: _____

Work Number: _____

Father's Name: _____

Cell Number: _____

Work Number: _____

Emergency Contacts other than parents:

Name: _____ Relation to child: _____

Phone Number: _____

Name: _____ Relation to child: _____

Phone Number: _____

Please note anything else we should be aware of to help us best take care of your child:

_____

_____

_____

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EMERGENCY MEDICAL TREATMENT CONSENT

Student: _____ Date of Birth: _____

CONSENT FOR MEDICAL TREATMENT

In the event of illness or injury, I hereby authorize All Day Learning Centers (ADLC) staff with current first aid certification to administer first aid to my child, and I hereby authorize ADLC staff, or other employees of ADLC, to obtain emergency medical treatment for my child as deemed necessary, including administration of an anesthetic or other medication and surgery, and I hereby assume the cost of such treatment.
I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but it is given to provide authority and power on the part of ADLC to give specific consent to the diagnosis, treatment, or hospital care which in the best judgement of a licensed physician is deemed advisable. I understand that ADLC will make best efforts to notify me immediately should emergency treatment for my child become necessary.

RELEASE AND HOLD HARMLESS AGREEMENT

As part of the consideration for my child's participation in ADLC activities, I hereby release, hold harmless, and forever discharge ADLC, and all of its employees from any liability, claims, demands, actions, and cause of action whatsoever arising out of or related to any loss, property damage, or personal injury, including death, that may be sustained by me or my child or to any property belonging to me or my child while my child is enrolled in the school, except for damages caused by negligence of the school, and its employees. I assume full responsibility for any risk of loss, damage, or personal injury, including death, and for any property damage that may be sustained by me or my child as a result of my child's participation in ADLC activities.

PARENT/LEGAL GUARDIAN ACCEPTANCE

I have read and I understand this document, including the release and hold harmless portions of it.

Printed Name of Parent/Guardian: _____

Signature: _____ Date: _____

Insurance Information

Insurance Name:_____ Policy Number:_____

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REQUEST FOR WEBCAM ACCESS

We are pleased to offer the parents of our students a webcam service. The system uses the latest generation of cameras, provides high resolution video, and offers excellent security features for the school.

Fee for access will be $25 per month per sign on account for parents of currently enrolled students.

If interested, please complete and return this form.

Child's Name: _____

Parent Name: _____

Email address for Webcam access: _____

Parent Statement and Agreement

I request access to the ADLC webcam system. I will include $25 per month with my monthly tuition. If I am not happy with the webcam system, I may terminate my access to the system, with written notice, prior to the 1st of any given month. For security reasons, I will not share access codes, pictures, or video with anyone other than the child's parent/legal guardian.

Parent Signature: _____ Date: _____

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PARENT RECEIPT OF INFORMATION

I have received the parent handbook via email with the information listed below. I hereby agree to abide by the terms and conditions contained within.

- ☐ Parent Handbook
- ☐ Information to Parents Document
- ☐ Policy on the Release of Children
- ☐ Positive Guidance and Discipline Policy
- ☐ Policy on Methods of Parental Notification
- ☐ Policy on Communicable Disease Management
- ☐ Expulsion Policy
- ☐ Policy on the Use of Technology and Social Media
- ☐ Policy on Coronavirus Policies and Procedures

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature:_____ Date: _____