KOALA KARE, LLC ADMISSION FORM

Complete form and email it to koala.kare@yahoo.com. Registration takes 24 hours to process.

Child's Full Name | Date of Birth | School Attending

My child will attend Koala Kare on the following days:

My child will attend Koala Kare at the following times:

Start Date

Date of Withdrawal

Two weeks' notice given?
Yes No

Home Address | City | Zip

Parent or Guarding Name(s) | Primary Phone Number | Alternate Phone Number

Email | Emergency Contact-NOT PARENT | Phone Number

Emergency Contact Address | City | Zip

I hereby authorize Koala Kare to release my child to the following persons:
(Please list names and telephone numbers for each. Students will only be released after verification of ID.)

I hereby authorize Koala Kare to release my child to the following sibling(s) under the age of 18

Please make a selection for each:

1. My child's vison/hearing screening, immunizations and TB test are on file at the school. ☐
2. I acknowledge receipt of the Koala Kare policies, including discipline and guidance. ☐
(A copy of our policies can be found on each campus or online at www.koalakare-llc.com.)
3. I give permission for my child to be served an afternoon snack. YES ☐ NO ☐

3. I understand that tuition payments are due on Friday for the next week's care (or the last school day of the week). Payment's received after Friday will incur a late fee of $10 per day. ☐

4. I understand the a charge of $3 per minute will be assessed to my account for pick-up after 6PM : ☐

MEDICAL INFORMATION AND SPECIAL NEEDS :

Please list any special conditions your child may have, such as allergies, existing illnesses or injuries, prescribed medications, and any information which care givers should be aware of:

To my knowledge, my child has not existing illness, injury or special needs. ☐

AUTHORIZATION FOR MEDICAL EMERGENCY ATTENTION

I give consent for the facility to secure any and all necessary medical care for my child. ☐

In the event I cannot be reached, I authorize Koala Kare employees to take my child to the nearest emergency facility. ☐

Primary Physician Name | Office Phone

Office Address | City | Zip

VERIFICATION OF INFORMATION : My signature below signifies that the information provided on this form is true and accurate to the best of my knowledge.

_____ _____

Signature of Parent of Legal Guardian
(Forms can be signed on the first day of care.)

Date

FOR OFFICE USE ONLY – DO NOT COMPLETE: REGISTRATION FEE

Date Paid ____/____/____ Amount $_____ CC____ Check#_____ Cash_____

Notes: _____

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