K.C.'S 24 HR. CHILD CARE CENTER
5119 HWY 278 NE
COVINGTON, GEORGIA 30014
770-787-9000 (fax) 770-787-9567
EMAIL:kcs24hrccc@bellsouth.net

DROP-IN REGISTRATION

CHILD'S NAME:_____ **DOB:**_____

HOME ADDRESS:_____
NUMBER & STREET CITY STATE ZIP

HOME TELEPHONE #_____ **WORK PHONE#**_____

MOTHER'S FULL NAME:_____

SOCIAL SECURITY #____-___-____ **DRIVER'S LICENSE #**_____

FATHER'S FULL NAME:_____

SOCIAL SECURITY #____-___-____ **DRIVER'S LICENSE #**_____

MEDICAL INFORMATION

CHILD'S PHYSICIAN :_____

PHYSICIAN'S ADDRESS:_____

PHYSICIAN'S PHONE #:_____

CHILD'S ALLERGIES:_____ ☐ **NONE**

EMERGENCY CONTACTS AND PERSON (S) CHILD MAY BE RELEASED TO

NAME:_____ **PHONE #**_____

ADDRESS:_____

NAME:_____ **PHONE #**_____

ADDRESS:_____

PARENT'S CONSENT'

SHOULD _____SUFFER AN INJURY OR ILLNESS WHILE IN THE CARE OF K.C.'S AND THE CENTER IS UNABLE TO CONTACT ME IMMEDIATELY, IT SHALL BE AUTHORIZED TO SECURE SUCH MEDICAL ATTENTION AS NEEDED FROM THE EMERGENCY ROOM OF NEWTON MEDICAL CENTER. I SHALL ASSUME ALL FINANCIAL RESPONSIBILITIES FOR PAYMENT OF SUCH SERVICES.

PARENT SIGNATURE:_____ **DATE:**_____

REVISED 1/2015

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VEHICLE TRANSPORTATION AND EMERGENCY MEDICAL AUTHORIZATION

PERSONAL INFORMATION

CHILD'S NAME: _____ **BIRTHDAY:** _____

ADDRESS:_____
STREETADDRESS CITY STATE ZIP

MOTHER'S NAME:_____ **PHONE:**___(____)_____(____)_____
HOME WORK

FATHER'S NAME:_____ **PHONE:** __(____)_____(____)_____
HOME WORK

Person to contact in an EMERGENCY when parents cannot be reached:

NAME:_____ **PHONE:**__(____)_____(____)_____
HOME WORK

MEDICAL INFORMATION

CHILD'S PRIMARY SOURCE OF HEALTH CARE IS:
_____ **PHONE:**____(_____)_____
PHYSICIAN/CLINIC NAME

LIST ANY KNOWN ALLERGIES: _____ ☐ NONE

LIST CURRENT PERSCRIBED MEDICATIONS: _____ ☐ NONE

LIST ANY SPECIAL NEEDS OR CONDITIONS: _____ ☐ NONE

THE CENTER USES THE FOLLOWING MEDICAL FACILITY:_____PIEDMONT NEWTON HOSPITAL_____
ADDRESS: __5126 HOSPITAL DRIVE NE, __COVINGTON, GEORGIA 30014 PHONE: (770) 786-7053_____

TRANSPORTATION ARRANGEMENTS

NAME OF CHILD'S SCHOOL: _____

CHILD'S SCHOOL IS APPROXIMATELY_____ MILES FROM K.C.'S 24 HR CHILD CARE CENTER.
MY CHILD WILL BE TRANSPORTED FROM K.C'S AT_____ A.M. AND DELIVERED TO ABOVE MENTIONED SCHOOL BY _____ P.M.
TRANSPORTATION WILL OCCUR ON THE FOLLOWING DAYS: ___ MONDAY ___ TUESDAY ___WEDNESDAY __ THURSDAY___ FRIDAY

EMERGENCY MEDICAL ARRANGEMENTS

IN THE EVENT OF AN EMERGENCY INVOLVING MY CHILD, I HEREBY AUTHORIZE K.C'S 24 HOUR CHILD CARE CENTER TO SECURE ANY NEEDED EMERGENCY MEDICAL ATTENTION AND CARE. I FURTHER AGREE TO BE FULLY RESPONSIBLE EXPENSES INCURRED DURING THE TREATMENT OF MY CHILD. I AGREE TO KEEP THE FACILITY INFORMED OF CHANGES AND TELEPHOME NUMBERS, ETC. WHERE I CAN BE REACHED. THE FACILITY AGREES TO KEEP ME INFORMED OF ANY ACCIDENTS REQUIRING PROFESSIONAL MEDICAL ATTENTION INVOLVING MY CHILD.

TRANSPORTATION AUTHORIZATION

THIS IS TO CERTIFY THAT I GIVE K.C'S 24 HOUR CHILD CARE CENER PERMISSION TO TRANSPORT MY CHILD TO AND FRON HIS/HER SCHOOL AND THE CENER AS OUTLINED ABOVE. IN THE EVENT THAT MY CHILD IS NOT TO BE TRANSPORTED AS OUTLINED ABOVE I WLL NOTIFY THE CENTER BY 12:00 NOON. IN THE EVENT THAT MY CHILD IS NOT RECIEVED BY THE CENTER AS SCHEDULED K.C'S WILL CONTACT ME AS SOON AS POSSIBLE.

PARENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE:_____ **DATE:**_____

REVISED 09/2026