DOUGLAS PREP ACADEMY

"Reaching the Hearts of Children in Early Care and Education"

Enrollment Application

Student Information

Full Name: _____ Birth Date: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

MY CHILD HAS SPECIAL NEEDS AND NEED ACCOMMODATION? YES ☐ NO ☐ If yes, please explain? _____

Parent Information

MOTHER'S NAME_____PHONE#_____

MOTHER'S HOME ADDRESS (IF DIFFERENT FROM CHILD'S)_____

CITY_____STATE_____ZIPCODE_____

MOTHER'S PLACE OF EMPLOYMENT_____WORK#_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIPCODE_____

FATHER'S NAME_____PHONE#_____

FATHER'S ADDRESS (IF DIFFERENT FROM CHILD)_____CITY_____STATE_____ZIP_____

FATHER'S PLACE OF EMPLOYMENT_____WORK#_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIPCODE_____

CHILD'S LIVING ARRANGEMENT: (CHECK ONE): Both ☐ Mother ☐ Father ☐ Other ☐

CHILD'S LEGAL GUARDIAN: (CHECK ONE): Both ☐ Mother ☐ Father ☐ Other ☐

Child Have Siblings? Please list name & ages:

4760 Industrial Access Road, Douglasville, GA 30134 **P:** (678) 402.6858 **F:** (555) 555.0124 **E:** douglasprepacademy@gmail.com

Authorizations, Permissions, and Other Data

Please list two people who are authorized to pick-up your child other than the authorized legal guardian or parent:

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Code word: _____

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Code Word: _____

EMERGENCY CONTACTS

May we contact your authorized pick-up person in case of an emergency. If no, please list emergency contacts: YES ☐ NO ☐

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Code Word: _____

Emergency Contact # 2

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Code Word: _____

CURRENT MEDICATIONS:

Doctors Information

Doctors Name: _____ Phone: _____ Email: _____

Address: _____ Insurance Company Name: _____

Current
Medications/Allergies/
Special Diet, explain: _____

Disclaimers and Signatures

I certify that my answers are true and complete to the best of my knowledge. If this application leads to enrollment, I understand that false or misleading information in my application may result in my child's dismissal from our program.

Print Name: _____ Date: _____

Signature of Authorized Parent and/or Legal Guardian: _____

If _____(Insert Child's name) experiences an accidental injury or illness while in the care of ***DOUGLAS PREP ACADEMY*** *and the facility is unable to contact a parent or guardian 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.*

Signature of Authorized Parent and/or Legal Guardian: _____

EMERGENCY MEDICAL AUTHORIZATION

If _____(Insert Child's name) experiences an accidental injury or illness while in the care of ***DOUGLAS PREP ACADEMY*** *and the facility is unable to contact a parent or guardian immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I the Parent or Guardian shall assume responsibility for payment for services.*

Child's Name:_____ Date of Birth:_____

Parent/Guardian Name & Number:_____

Signature:_____ Date: _____

Facility Administrator/Person-In-Charge: _____

Signature: _____ Date:_____

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____
(Not to exceed two weeks without a physician's statement)

_____ _____
PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)

	DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	ADMINISTERED BY
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication

DOUGLAS PREP ACADEMY PHOTO RELEASE FORM

This form is for permission to display photos of your child. We like to take pictures of the children playing and doing some special activities and then display them in the daycare center. This is a great way to share with parents what the children are doing while they are in daycare. The children really enjoy looking at pictures of their friends and themselves. We will, at times place these pictures on any social media, website or advertisement platform.

Please indicate below if we may use your child's photograph for the use mentioned above and return this form.

_____ I grant permission to DOUGLAS PREP ACADEMY to use my child's photograph for the uses mentioned above.

_____ I do not give permission to DOUGLAS PREP ACADEMY to use my photograph for any use my child's photograph for any use.

Child's Name _____

Parent/Guardian _____Date_____

Parent/Guardian _____Date_____

CHILD'S SCHEDULE AND INTERESTS

The following information will assist the provider to understand and care for your child.

Please describe your child's eating habits, i.e. food likes and dislikes, etc.
NOTE: Complete **INFANT FEEDING PLAN** (next page) for children who are under 1 year of age.

Describe the play activities that your child likes, both indoors and out-of-doors.

Describe your child's naptime habits.

Describe your child's toilet and hygiene habits.

Please add any other special information that is important to your child's care here:

Does your child have any known allergies? Yes No If yes, please explain:

Does your child have any known medical problems? Yes No If yes, please explain:

Please read the statement	below and initial the box to the left if you have provided this information.
	My child has known allergies and/or other medical problems. I have requested from my provider and completed a **MEDICAL CARE AND EMERGENCY CONTACT INFORMATION** form in order to provide this detailed information.

Parent/Guardian _____ **Date**

INFANT FEEDING PLAN

Child's Full Name _____ Date _____

Date of Birth _____

Does the child take a bottle?	Yes [ ]	No [ ]
Is the bottle warmed?	Yes [ ]	No [ ]
Does the child hold own bottle?	Yes [ ]	No [ ]
Can the child feed self?	Yes [ ]	No [ ]

Does the child eat: (check all that apply)

Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used, if applicable?_____
Amount and time of formula/breast milk to be given?_____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: _____

The child has reached the following developmental skills:

Can hold his/her head steady?	Yes [ ]	No [ ]
Opens mouth/leans forward in anticipation of food offered?	Yes [ ]	No [ ]
Closes lips around a spoon?	Yes [ ]	No [ ]
Transfers food from front of the tongue to the back and swallows?	Yes [ ]	No [ ]

Instructions for the introduction of solid foods _____

_____

Food likes _____

Food dislikes _____

Allergies? (including any premixed formula)_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

PARENT'S SIGNATURE: _____ Date: _____

Infant Affidavit 

Name of Sponsor (if applicable) _____

Name of Provider/Center _____

Name of Infant: _____

Infant Date of Birth: _____

Name of Parent/Guardian:

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: _____
Center/provider will provide the following Iron-fortified infant cereal: _____
Center/provider will provide the following brand of infant foods: _____

Parents/Guardians,

Please check one of the following options below and sign this form:

_____ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

_____ I will provide the following meal component to my infant and the center will provide all other meal components:

- ☐ Formula*
- ☐ Cereal
- ☐ Fruit
- ☐ Vegetable
- ☐ Meat/Fish/Poultry/Eggs/Beans/Peas
- ☐ Cheese/Cottage Cheese/Yogurt
- ☐ Bread/Crackers/Breakfast Cereal

_____ _____

Parent/Guardian Signature Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply.** (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? $_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Welfare, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

Circle the meals your child will normally receive while in care: **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

PART IV: Signature
*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care.* ***If not completed fully and signed, the participant will be placed in the Paid category.***

Signature: X _____ **Print Name:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility:** check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

Parental Agreements with Child Care Facility

The _____ agrees to provide child care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
(Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked 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 contacts, child's physician, child's health status, infant feeding plans 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.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility 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
_____.
(Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating 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 facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)