WELCOME TO PREK

Forms needed:

1. **Registration Form**
2. **Roster Form**
3. **Birth Certificate**
4. **Proof of Residency**
5. **Immunization (3231)**
6. **Eye, Ear, Dental , Nutrition (3300)**
7. **Social Security Card**
8. **Proof of Foodstamps, Medicaid, Peachcare, CAPS, SSI, TANF (If Applicable)**

PRE-K SUPPLY LIST

1. Box Crayons (8 count)
2. Pair of Scissors (Blunt Tip)
3. Glue Sticks (3)
4. Bottle Glue 4oz (2)
5. Pencils/ 2 large Pencils and 1 Box
6. Pkg Construction Paper (2) Assorted Colors
7. Box Tissues (2)
8. Box Washable Markers (Primary Colors)
9. Roll Paper Towels (2)
10. Sanitizer (1)
11. Container Baby Wipes (2)
12. Package Paper Plates (1)
13. Band-Aids (1 Box)
14. Disinfectant Spray (2 Cans)
15. Clorox Wipes (3)
16. Plastic Zipper Bags – 1 box each size, Snack, Sandwich, Quart, Gallon
17. Black Dry Erase Markers (2)
18. Change of Clothes (please make sure to include underwear and socks) – Include child's name on all clothing/please put name on outside of Ziploc bag.

BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |			
CHILD'S FIRST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |			
CHILD'S MIDDLE NAME: | | | | | | | | | | | | | | | | | | NAME SUFFIX:| | | | (i.e. Jr, Sr, II,III)			
CHILD'S SOCIAL SECURITY#:		D.O.B. (MM/DD/BY):	SEX: [ ]M [ ]F
HOME ADDRESS (*Do not enter PO Box Info*):			COUNTY:
CITY:	STATE: GA	ZIP:	HOME PHONE: ( )

If the Student is transferring from another Pre-K, please provide the following:
Previous School Name: _____ Last Date in Attendance: _____

PARENT/GUARDIAN INFORMATION			
Parent/Guardian #1 - LAST NAME:		FIRST:	MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: ( )	
Email Address:			
Place of Employment:		Work Phone: ( )	
Address:			
City:	State:	Zip:	
Parent/Guardian #2 - LAST NAME:		FIRST:	MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: ( )	
Email Address:			
Place of Employment:		Work Phone: ( )	
Address:			
City:	State:	Zip:	

EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)				
NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.				
2.				

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

Signature Parent/Guardian: _____ **DATE:** _____

CHILD MAINTENANCE
CHILD'S LIVING ARRANGEMENTS: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER
CHILD'S LEGAL GUARDIAN: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER
THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING: NAME ADDRESS RELATIONSHIP CELL PHONE
1.
2.
3.
4.
CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): _____. DATE OF LAST FULL HEALTH SCREENING:_____ PHONE: ( )
MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):
THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:
MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: _____

SIGNATURE (Parent/Guardian): _____

DATE: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate. *(Por favor escriba el nombre como aparece en el certificado de nacimiento.)*

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal Last Name *(Apellido):*		Name Suffix (Sufijo) (Jr,II,III):
Legal First Name *(Primer Nombre):*		Name Child is Called:
Legal Middle Name *(Segundo Nombre):*		
Child's Social Security# ____-____-____	DOB *(Fecha de Nacimiento)* *(M/D/Y):* ____/____/____	Gender *(Sexo):* M ☐ F ☐
Date enrolled in Pre-K (M/D/Y): ____/____/____		
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	

1. Is your child's ethnicity **Hispanic/Latino/Spanish Origin,** regardless of race? *(¿Es Ud. **Hispano/Latino o de Origen Hispano,** sin importar la raza?)*

☐ **Yes** *(Si)* ☐ **No** *(No)* ☐ **Decline to Answer** *(negarse a contester)*

Please select **ONE OR MORE** of the following races regardless of how you answered question one. *(**TODOS** deben seleccionar **UNA O MAS** de las siguientes razas sin importar cómo haya contestado la primera pregunta.)*

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. *(**Blanco** – Una persona que tiene orígenes en los pueblos provenientes de Europa, el Medio Oriente, o Africa del Norte).*

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *(**Asiática** – Una persona con orígenes en los pueblos provenientes del Lejano Oriente, Suroeste de Asia, o el subcontinente Hindú incluyendo, a Cambodia, China, India, Japón, Corea, Malasia, Pakistán, Las Filipinas, Tailandia, y Vietnam.)*

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. ***(Nativo de Hawaii u Otra Isla del Pacífico** – Una persona con orígenes en los pueblos provenientes de Hawaii, Guam, Samoa, u otra Isla del Pacifico.)*

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa. ***(Negro o Afro Americano** – Una persona con orígenes en los pueblos provenientes del Africa o en grupo racial Negro.)*

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment. ***(Indio Americano o Nativo de Alaska** – Una persona con orígenes en los pueblos provenientes de América Del Norte y del Sur, incluyendo América Central, que mantiene una afiliación tribal o comunitaria.)*

☐ f. **Decline to Answer** *(negarse a contester)*

3. What is your child's primary language? *(¿Cuál es el idioma primario de su hijo(a)?)*

☐ **English** *(Inglés)*

☐ **A language other than English** *(Un idioma diferente al Inglés)*

4. Was your child born as a: *(El parto en que Ud. tuvo a su hijo(a) fue de:)*

☐ **Single Birth (1)** *(Un sólo niño)*

☐ **Twin (2)** *(De mellizos)*

☐ **Triplet (3)** *(De trillizos)*

☐ **Quadruplet (4)** *(De cuatrillizos)*

☐ **Quintuplet (5)** *(De quintuples)*

5. Does your child have an Individualized Education Plan (IEP)? *(¿Tiene su hijo(a) un Plan de Educación Individualizada (IEP?))*

☐ **Yes** *(Si)* ☐ **No** *(No)*

6. Does your child receive any of the following services? *(¿Recibe su hijo(a) alguno de estos servicios?)*

☐ **Childcare and Parent Services (CAPS) (child care subsidy program)**

☐ **Food Stamps** *(Cupones de Alimentos)*

☐ **SSI**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

7. Will the Pre-K center be providing transportation for your child? *(¿Recibirá su hijo(a) transporte en el Centro donde va a asistir a Pre-K?)*

☐ **Yes** *(Si)* ☐ **No** *(No)*

Parent/Guardian Signature **Date**

Parental Agreements with Child Care Facility

The Little Scholars Academy (LSA) agrees to provide child care for
(Name of Facility)
_____ on M-F 8 a.m. to 6 p.m.
(Name of Child) (Days of Week)
from Jan to Dec.
(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 LSA 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
LSA.
(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: Felicia Conn-Payton Date: _____
(Facility Administrator/Person-In-Charge)

Parental Agreements with Child Care Facility

The Little Scholars Academy (Name of Facility) agrees to provide day care for _____ (Name of Child) on M-F (Days of Week) 8 a.m. to 6 p.m. from Jan Month to Dec. 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 LSA 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 LSA (Name of Facility).

I understand that the center 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)

EMERGENCY MEDICAL AUTHORIZATION

Should _____, _____suffer an injury or illness while in the
Child's Name Date of Birth
care of _____and the facility is unable to contact me/us immediately,
Name of Facility
it shall be authorized to secure such medical attention and care for the child as may be necessary. I/We agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of health care is:

_____

Physician/Clinic Name Telephone Number

Know medical conditions (i.e.) diabetic, asthmatic, drug allergies:

_____

_____

_____

_____

Signature of Parent/Guardian Date Telephone

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

Center Name:LITTLE SCHOLARS ACADEMY

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 Income1 - 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 Members1. List all household members (including yourself) not listed in Part I even if they do not receive income. 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 ☐ I do not have a Social Security Number

PART III: ENROLLMENT INFORMATION ***:Children Only***

My child is normally in attendance at the facility between 8 [am] / pm] to 5 [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: GA 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: _____ ☐ Week ☐ Every 2 Weeks ☐ Twice a month ☐ Month ☐ Year Household Size:0

Categorical Eligibility:(check if applicable ☐ **Eligibility**: check one Free ☐ Reduced ☐ Paid-Denied ☐

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:** _____