



Constructing a strong foundation for the future....

2591 Jerome Road*College Park, Georgia*30349*404-761-9026

- HOURS:** 6:30 A.M. TO 6:00 P.M. Monday through Friday
- PROGRAM:** Includes breakfast served 7:30 am to 8:00 am, nutritious lunch, and afternoon snack
- HOLIDAYS:** New Year's Day, M.L. King Day, President's Day, Memorial Day, Independence Day, Labor Day, Indigenous People Day, Thanksgiving Holidays, Christmas Break. We will be closed for periodic teacher work days. We will announce these as soon as they are planned. Since we are a full time-year-around center, no discounts will be made for holidays or other days on which the facility does not operate or open late for whatever reason, including but not limited to inclement weather.

Full Time Care	Rate
Baby Scholars – 12 months to 18 months	\$175
Little Einstein's – 24 months (2 year old)	\$165
Little Scholars – 3 years	\$150
Pre-K	FREE
Before Care (6:30 am – 8:00am)	\$55
After Care (3pm -6pm)	\$75
Registration Fee	\$30

Policies:

- Tuition is due on Monday the week of service. Payments must be made by Friday before 2:30 PM. If not paid, tuition is late and will be charged an \$18 fee.
- We offer a 10% discount off the oldest sibling on full time programs.
- A \$25 fee will be assessed for all returned checks. We do not hold checks for later deposit.
- If you pick your child up after 6:00 p.m. the following fees will be imposed:
 - 6:01-6:15 pm \$8.00
 - 6:15-6:30 p.m. \$18.00
 - 6:30 –Until \$18 plus \$3.00 per minute.
 - Phone calls to notify of later arrival will not exempt a late fee charge. Accounts will be billed
- We request your child's immunization record (Form 3231) within the first 30 days of enrollment.
- Please remember to sign your child in/out everyday
- Please remember to keep a clean change of clothes in your child's cubby. Toddler parents may want to leave more than one change of clothes.
- We recommend that you send your children to school in clothes that are suitable for all types of activities including those that might stain or damage clothing
- We also recommend that you send your child/children to school in shoes with a back heel strap or closed heel.
- Please refrain from sending your child to school with toys or snacks from home.
- Toddler parents please send at least 8 pampers/pull ups per day. You may also leave a pack of pampers with your child's teacher.
- Please ensure your child arrives to school at appropriate time.
 - GA Pre-K child who are not enrolled in extended day must be at school no later than 8:30 am. Excessive tardiness can result in dismissal from the program.
 - If you would like for your child to eat breakfast, he/she must be present no later than 8:00am
 - We ask that children be here no later than 9:00am
- There are 3 illnesses that require your child to stay at home for 24 hours:
 - Fever of 101 or higher
 - Diarrhea (2 or more times)
 - Vomiting (2 or more times)
- Hiring of our teachers and staff by parents is highly discouraged. If you arrange with a staff member for off-premises care of your child, that staff member undertakes such services on his/her own behalf and not as a representative of Little Scholars Academy.
- Parents are permitted access to the center at any time their child is present. However, we request cooperating and not disturbing our program.
- Little Scholars Academy requires a two-week notice for any schedule change in your child's care, including withdrawal. If you do not give a two weeks' notice, you must pay two week's tuition in lieu of notice.
- We reserve the right to disenroll children that do not adjust to our program.
- We accept children without regard to race, color, or national origin
- Please direct all concerns to the Director/Owner. Please do not address teachers with concerns.

I/We have read, understood and agree to the above prices and policies.

Parent/Guardian Signature _____ Date: _____

EMAIL Address: _____

SAMPLE CHILDREN'S ENROLLMENT FORM

Entrance Date _____ Withdrawal Date _____

Child's Name _____ Sex _____ Age _____ Date of birth _____

Home Address (Street) _____

City _____ State _____ Zip _____

Home Phone Number _____

Father's Name _____ Home Phone Number _____

Father's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Father's Place of Employment _____ Work Phone _____

Employer's Street Address _____ City _____ State _____ Zip _____

Mother's Name _____ Home Phone Number _____

Mother's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Mother's Place of Employment _____ Work Phone # _____

Employer's Street Address _____ City _____ State _____ Zip _____

Child's Living Arrangements: (check one) Both Parents Mother Father Other

Child's Legal Guardian(s): (check one) Both Parents Mother Father Other

The child may be released to the person(s) signing this agreement or to the following:

*Name _____ Address _____

(Street-City-State-Zip)

Telephone Number _____ Relationship to child _____

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

*Name _____ Address _____

(Street-City-State-Zip)

Telephone Number _____ Relationship to child _____

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name _____

Doctor/clinic phone # _____

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth _____
suffer an injury or illness while in the care of (Facility name) _____
and the facility is unable to contact me (us) 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.

Parent/Guardian: _____

Signature

Date: _____

Felicia Ann Payton

Facility Administrator/Person-In-Charge _____

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) from Jan to Dec (Month) (Days of Week) (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: (Parent/Guardian) Date:

Signed: Felicia Cma. Payton Date: Facility Administrator/Person-In-Charge

**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 FDIPIR 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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Child Income/How often? (i.e., weekly, monthly, etc.)
income received by child household members listed in PART I here. \$ _____/_____

B. Other Household Members¹. 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 along the frequency i.e., twice a month, weekly, etc. 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. Subsidies, 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 Part II B is completed and household members are listed (with or without income), 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: The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only.
Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.

Check (✓) one ethnic identity: <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/ Latino	Check (✓) one or more racial identities: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiracial
---	--

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: _____