SCHOOL AGE ENROLLMENT CHECKLIST

Parents,

This is a checklist of all the items that you need to have before your child may start his/her first day at Bright Stars Primary Learning Academy, LLC. You must fill out, date & sign this checklist.

_____ $65 registration fee (paid at time of enrollment)
_____ First week's tuition (paid at time of enrollment)
_____ Birth certificate
_____ Most current Immunization records (Form 3231)

COMPLETED ENROLLMENT PACKET:

_____ Parent Handbook (Please sign pages 17-18 and return with Enrollment Packet)
_____ Enrollment form
_____ Copy Parent(s) D.L. and SSN Card
_____ Tuition Fee Agreement
_____ Authorization for Pick-Up
_____ Parental and Facility Agreement (BSPLA)
_____ Child Medical Treatment Form
_____ Food Allergy Action Plan
_____ Preventative Products Approval
_____ Benefit Income Eligibility Forms (2 pages)
_____ Community Childcare Food Supplement Distribution Log
_____ WIC
_____ Parental Enrollment Agreement with Child Care Facility (CCFS)
_____ Household Letter Instructions
_____ Vehicle Emergency Medical Information
_____ Transportation Agreement
_____ No Liability Insurance Parent Acknowledgement
_____ Official start date: _ _____
_____ School child's attend: _____

_____ _____
Parent Signature (Mom) Date

_____ _____
Parent(s) Signature (Dad) Date

Discipline and Behavior Policy

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, Bright Stars Primary Learning Academy uses a positive approach to discipline and practices the following discipline and behavior management techniques.

WE DO

Communicate to children using positive statements on their level.
Talk with children in a calm quiet manner.
Explain unacceptable behavior to children.
Give attention to children for positive behavior.
Praise and encourage the children.
Reason with and set limits for the children.
Apply rules consistently.
Model appropriate behavior.
Provide alternatives and redirect children to acceptable activity.
Give children opportunities to make choices and solve problems.
Help children talk out problems and think of solutions.
Listen to children and respect the children's needs, desires and feelings.

WE DO NOT

Inflict corporal punishment in any manner upon a child.
Use food as a form of reward or punishment.
Use or withhold physical activity as a punishment.
Shame or punish a child if a bathroom accident occurs.
Embarrass any child in front of others.
Compare children.
Leave any child alone, unattended or without supervision.
Allow discipline of a child by other children.
Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary/behavior problems occur. If your child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.
Note: If, at any point, there is an indication/suspicion that a child may have special needs, Bright Stars Primary Learning Academy will inform the child's family and make contact with Baby Babies Can't Wait or EAP for assessment and assistance.

My signature below indicates that I have received a copy of the discipline policy, it has been reviewed with me, and I have read and understand this policy.

Signature_____ **Date**_____
Please circle as appropriate: PARENT, GUARDIAN, FOSTER PARENT
Name of child_____

Policy Agreement Form

Child's Name_____
Start Date _____
Address _____
Phone # _____

Bright Stars Primary Learning Academy, LLC Parent Handbook was created to promote an understanding of the policies and procedures at Bright Stars Primary Learning Academy, LLC. The information in the Parent Handbook applies to all enrolled children at Bright Stars Primary Learning Academy, LLC. It is important that parents and children are familiar with these expectations.

Please be sure to read the Parent Handbook in its entirety, complete this form, and return it with the other required forms to the center. Your child will not be allowed to start at Bright Stars Primary Learning Academy, LLC without having completed and returned this form. Your signature means that you have received, read, and understand the policies and procedures of Bright Stars Primary Learning Academy, LLC.

I have read and understand the policies and procedures in the Bright Stars Primary Learning Academy, LLC Parent Handbook. I agree to abide by them as will my child (ren).

Parent Name (PRINT) _____ Date _____

Parent Signature_____

Parent Name (PRINT) _____ Date _____

Parent Signature_____

CHILDREN'S ENROLLMENT FORM

Entrance Date: _____ **Withdrawal Date:** _____

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

Home Address (Street)_____

City_____ **State**_____ **Zip** _____

Mother's Name_____ **Home Phone Number**_____

Mother's Email_____ **Social Security 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**_____

Father's Name_____ **Home Phone Number**_____

Father's Email _____ **Social Security Number**_____

City_____ **State** _____ **Zip**_____

Father'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

Bright Stars
Primary Learning Academy

RELEASE AUTHORIZATION/EMERGENCY CONTACT FORM

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

Name_____

Address_____

City _____ **State**_____ **Zip Code**_____

Telephone Number_____ **Relationship to child**_____

Other identifying information (if any) _____

Name_____

Address_____

City _____ **State**_____ **Zip Code**_____

Telephone Number_____ **Relationship to child**_____

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**_____

MEDICAL INFORMATION

Doctor/Clinic Name _____

Address_____ **Phone Number** _____

City _____ **State** _____ **Zip Code**_____

Dentist Name_____

Dentist Address _____ **Phone Number**_____

City_____ **State**_____ **Zip Code**_____

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:

_____

_____

_____

List allergies to the following: (Input N/A on each line if not applicable)

Medications: _____

Food: _____

Environment: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth_____

suffer an injury or illness while in the care of Bright Stars Primary Learning Academy, LLC 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_____

Facility Administrator/Person-In Charge_____

Signature_____Date: _____

MEDICAL AUTHORIZATION AGREEMENT

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.

Parent/Guardian:_____

Signature:_____

Date: _____

Tuition Fee Agreement

Child's Name: _____ Date of Birth_____

Date of Enrollment: _____ □ Full Time □ Part Time M T W Th F

Child's Arrival Time: _____ Child's Departure Time: _____

Tuition Fee(s): _____

□ **Weekly Tuition** – weekly tuition is due each Monday before services are provided for the current week.

□ **Monthly Tuition** – monthly tuition is due on the 1st day of each month before services are provided.

□ **Identification** – provide copy of State issued ID card.

1. An annual, non-refundable family Registration Fee is to be paid at time of Enrollment. Registrations Fees are renewed September 1st each year and must be paid in full by September 30th.

2. The Center is open from **6:00 a.m**. to **7:00 p.m.** Monday thru Friday. A Late Pick-Up fee of $5 per minute per child will be charged when a child is left past the center's closing time. If I or other authorized persons do not pick up my child and/or do not contact the center, and after the center staff exhaust all attempts to reach authorized persons, as per state child care licensing regulation, the center staff may release children to the custody of child protective services or local authorities within thirty minutes after closing time.

3. Tuition fees are not pro-rated for illness, holidays, or emergency closures of the center. Each family receives 2 credit weeks per enrollment year for vacations or time off. Vacation credits should be requested in writing and consists of Monday-Friday period of time. (This does not apply for Subsidized Families based on CAPS policies and procedures)

4. Tuition is due in advance of services provided. Tuition payments received after the close of business on Friday will be subject to a $20 Late Fee.

5. Accounts that are two weeks behind may result in immediate termination of service; however, once balance is paid, the child may return into care

6. Two week written notice is required prior to withdrawing. All balances must be paid in full by last day of attendance. Any outstanding balance will be referred to a collection agency and subsequent legal action. All fees associated with collections or attorney charges will be added to the collection account.

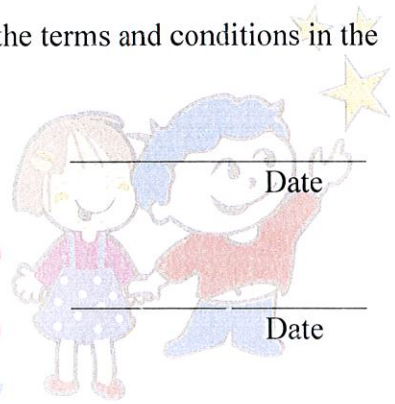
7. I agree to notify the center by **9:00am** when child is absent. I must notify center staff if my school age child does not need to be picked up from school or will not arrive at their designated bus stop.

8. If my child attends our school age program and school is not in session due to public school closing or snow. If school is not in session for the entire week and my child attends Monday - Friday, the weekly tuition will be applied to my account.

9. The terms of this Agreement, including tuition, fees and policies are able to be changed by Bright Stars Primary Learning Academy with 30 days' notice. This agreement can be terminated by the center at any time.

10. Bright Stars Primary Learning Academy reserves the right to dis-enroll any child without notice if it is in the best interest of the child or the program. This will not occur without appropriate attempts being made to resolve any issues or concerns.

I certify that I have read, understand and accept all of the terms and conditions in the Parent/Guardian Agreement.



_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Center Director Signature Date

Bright Stars
Primary Learning Academy

Authorization for Pick-Up

We will not release your child to anyone without parent or guardian authorization.

The individuals listed below, as well as those listed on the Medical Treatment Permission form have my permission to pick up my child, _____ from Bright Stars Primary Learning Academy. These people must show photo ID in order to pick up the child.

Name	Relationship to Child
Address	Phone #
Name	Relationship to Child
Address	Phone #
Name	Relationship to Child
Address	Phone #
Name	Relationship to Child
Address	Phone #

Special Circumstances:
If a child's parent, is denied contact with the child, it is necessary to have a copy of the court document that grants full custody or orders a restraint against the parent. It is your responsibility to notify BSPLA in writing if the situation changes.

The following individuals are specifically denied permission to pick up my child:

Name	Relationship to Child
Address	Phone #
Name	Relationship to Child
Address	Phone #

I agree and by my signature give consent that in case of an accident, injury, or illness, my child _____, will be given emergency medical care. Basic first aid will be administered by a certified staff member. If the accident/injury is of a more serious nature, 911 will be called and transportation will be provided by ambulance to the Southern Regional Hospital or the closest hospital. I will be contacted immediately; if for any reason I am not able to be reached in a timely manner my emergency contact will be called.

Parent or Legal Guardian Signature	Date
Director or Designee Signature	Date

PARENTAL & FACILITY AGREEMENT

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.

Bright Stars Primary Learning Academy, LLC 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 Bright Stars Primary Learning Academy, LLC 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 Bright Stars Primary Learning Academy, LLC.

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 Administration)

Child Medical Treatment Form

The following information will be kept on file for one year from the date signed. If any information changes, the parents or guardians need to promptly inform Bright Stars Primary Learning Academy in order for proper care to be given.

Physician's Name: _____
Address: _____
_____
Phone: _____

Dentist's Name: _____
Address: _____
_____
Phone: _____

Allergies to: Medications: _____
Food: _____
Environment: _____

Medications presently being taken and why: (Doctor's note is needed for medication administration by Bright Stars Primary Learning Academy staff).

History of illness we need to be aware of:

_____

_____

In the event your child becomes ill or injured while in the care of Bright Stars Primary Learning Academy, you the parent will be contacted first. Please name two individuals whom are able to act for you in case you cannot be contacted.

Name: _____ Relationship to the Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Relationship to the Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other†	_____	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room ____ ____

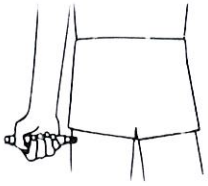
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- **Pull off green end cap, then red end cap.**

- **Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.**

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow or orange collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

The Food Allergy & Anaphylaxis Network

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Preventative Products Approval

With parent's written approval, we may use preventative products, such as sunscreens, insect repellents, non-medicated powder, Petroleum jelly, and A&D ointment, without a physician's order: Child Care Rule: 290-2-3.11 (1)(e)

Please check each product below that you choose to use for your child. Please mark Sunscreen, we go outside daily. If you want your child to use these products, you are responsible for providing each. All items need to be labeled with your child's name and brought in a large Ziploc bag.

_____ Sunscreen

_____ Lotion

_____ Insect repellent

_____ Non-medicated Powder

_____ Petroleum jelly

_____ Non-prescriptive ointment (A&D, Desitin, etc.)

_____ Chopstick

_____ Band-Aids

_____ Neosporin, Bacitrin or similar ointment

_____ other (please specify):_____

_____ _____

Child's Name Date

_____ _____

Parent's Signature Parent's Printed Name

Community Childcare Food Supplement Inc.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. _____ offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualities for free or reduced price meals.

1. *Do I need to fill out a Meal Benefit Form for each of my children in day care?* ***You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to:*** _____.

2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals. ***For more information on the Georgia's TANF and SNAP programs please call 1-877-423-4746 or visit*** www.gateway.ga.gov.

3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact _____.

9. **We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call _____.

Sincerely,

Your Daycare Center Provider

#04299 – Community Childcare Food Supplement, Inc.

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

Center Name: _____ **Phone#** _____ **Site#** _____

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

Name: (Last, First, and Middle Initial)	DOB	AGE	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 II.	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 (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 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 ☐ Year Household Size: _____

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: _____

WIC

A Special Food and Nutrition Education Program For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income
  AND
- Have a special need that can be helped by WIC foods and nutrition counseling

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

WIC

A Special Food and Nutrition Education Program For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income
  AND
- Have a special need that can be helped by WIC foods and nutrition counseling

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

I, _____, acknowledge receipt of the information about the WIC program. I understand that this information must be provided to every CACFP participant's family that completes an enrollment packet for the below named facility.

Center Name: _____

Recipient Signature: _____

Georgia WIC Program

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: http://dph.georgia.gov/WIC

INCOME ELIGIBILITY GUIDELINES
(Effective from July 1, 2018 to June 30, 2019)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member add	+ 7,992	+ 666	+ 333	+ 308	+ 154

#04299 Community Childcare Food Supplement, Inc.

Parental Enrollment Agreement with Child Care Facility

The _____ agrees to provide child care for, _____ on
(Facility's Name) (Child's Name)

Monday Tuesday Wednesday Thursday Friday
(please circle)

from _____ a.m. to _____ p.m.
(time during the day)

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

Breakfast Lunch Dinner

Morning Snack Afternoon Snack Evening 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 facility 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. 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.

I also have received a Household Letter and WIC information along with my child's enrollment packet and have read and understand the resources in the state of Georgia available to myself and my family.

Print Name: _____ Date: _____
(Parent/Guardian)

Address: _____ City: _____ Zip: _____

Phone #: _____ Email: _____

Signature: _____
(Parent/Guardian)

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

Signature: _____
(Facility Administrator/Person-In-Charge)

HOUSEHOLD LETTER INSTRUCTIONS
2018-2019

Insert center name, address, and phone number in the highlighted portions of this letter.

1. Center Name: Bright Stars Primary Learning Academy
2. Center Name and Address: 8733 Tara Blvd. Jonesboro, GA 30236
3. Director/Owner's Name and Phone Number:

Jasmin Quillian / Rhonda Davis

4. Center Phone Number:

(770) 892-0160 (office) (770) 892-0161 (fax)

Please five this letter to all parents of children enrolled in your facility. All parents must sign your **Distribution Log** stating that they received a Household Letter. Please keep Distribution Logs current and file onsite. We will ask to see your Distribution Log quarterly to ensure that all items are distributed accordingly.

BRIGHT STARS PRIMAY LEARNING ACADEMY

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Mother's Name _____

Home Phone _____ Work Phone _____

Father's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if _____
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

NOTICE TO PARENTS AND GUARDIANS:

THIS FACILITY DOES NOT CARRY LIABILITY INSURANCE COVERAGE SUFFICIENT TO PROTECT YOUR CHILDREN IN THE EVENT OF AN INJURY, ETC.

Posted per SB 24 (2004) requiring child care facility owners to post in a conspicuous place if it is not covered by liability insurance and to provide and retain written notice regarding no coverage to the parents and guardians.