BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form 2023-2024 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 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:

Georgia Dept of Early Care and Learning

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 sigulentes 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 _____
(Name of Facility)

agrees to provide child care for _____
(Name of Child)

on _____, beginning at _____AM
(Days of Week)

and ending at _____ PM 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, and Date and Time of Day to be given to child. 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(s) 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.

_____ 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'm not available.

I have received a copy and agree to abide by the policies and procedures for the above-named facility.

SIGNED: _____ _____
Parent/Guardian Date

SIGNED: _____ _____
Facility Administrator / Authorized Person Date

rgia Department of Public Health

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

arent/ Guardian Name: _____
first middle last

arent/ Guardian Contact Information:
ytime phone number: _____
ening phone number: _____
ll phone number: _____

Child's Name: _____
first middle last

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Child's Home Address:
_____
street city state zip code county

VISION

☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Optometrist
☐ "Prevent Blindness Georgia" employee
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

HEARING

☐ Unable to screen (explain why below)
☐ Uses hearing aid / assistive device

☐ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Audiologist
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

DENTAL

☐ Unable to screen (explain why below)

☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

NUTRITION

☐ Unable to screen (explain why below)

Height: _____ Weight: _____
BMI: _____ BMI%: _____

☐ 5th to 84th percentile - Appropriate for age
☐ < 5th percentile - Needs further evaluation
☐ ≥ 85th percentile - Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Registered Dietician
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

OR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
sion			
aring			
ntal			
trition			

udent support services initiated on:

Screeners' Comments: