Childs Name _____

Date of Birth_____ **Date Enrolled**_____

Check list

- GEMS Application
- Emergency Medical Form
- Parental Agreement
- Policies of GEMS
- Allergy Statement (Allergies must be noted during enrollment)
- Vehicle Emergency Medical/ Transportation Form
- Emergency Telephone Number
- Classroom Information Sheet (must be kept current at all times)
- CAPS Form (if applicable)
- Enrollment / Tuition Information
- Immunization Record (form 3231)
- Feeding Plan (if applicable)
- Copy of Birth Certificates
- Copy of Guardians Identification
- All USDA Forms Are Part of Application
- Form 3300 (Ear, Eye, and Dental
- Change of Clothing
- Payment for ABEKA Book
  - 2 years old class $27.50
  - 3 years old class $36.50
  - 4 years old class $52.75
  - 5 years old class $ __.__

Date Completed_____

Reviewed By _____ _____

Print Name Signature

GEMS LEARNING ACADEMY

8850 High Point Road

Union city, Georgia 30291

(770)306-6133

(770)306-6139

ENROLLMENT APPLICATION (please print clearly)

ENTRANCE DATE _____ WITHDRAWL DATE _____

CHILD'S NAME _____

Last First Middle Initial

Gender ____ Male ____ Female Age _____ Date of Birth_____

Sponsor's Name _____

Address _____

Number Street City State Zip Code

Cell Phone _____ Work Phone _____

Email Address _____

Employer _____

Address _____ Phone _____

Co Sponsor's Name_____

Address _____

Number Street City State Zip Code

Cell Phone _____Work Phone _____

Email Address _____

Employer _____

Address _____Phone _____

Child's Living Arrangements: ___ Both Parents ____ Mother ____ Father ____Other

Child's Legal Guardian: ____ Both Parents ____ Mother ____ Father ____ other

Authorization to Release Child

Parent authorizes GLA to release their child to the following persons:

Name _____

Address _____

Number Street City State Zip Code

Phone _____ Alternate Phone _____

Relationship to Child/Parent _____

Name _____

Address _____

Phone _____ Alternate Phone _____

Relationship to Child/Parent _____

Name _____

Address _____

Phone _____ Alternate Phone _____

Relationship to Child/Parent _____

In the case of an emergency who other than the parents may we contact?

Name _____

Address _____

Phone _____ Alternate Phone _____

Relationship to Child/Parent _____

My Child Attends the Following School (if Applicable)

Name of School _____

Address _____

Phone _____ Teacher's Name _____

GEMS LEARNING ACADEMY

Parental Agreement

GEMS LEARNING ACADEMY agrees to provide care for:

Child's Name _____

Meals

I agree to allow my child to participate in the following meal plan (Check all that applies)

_____*Breakfast* _____ *Lunch* _____ *Dinner* _____ *Supper*

Medicine Administration

Before any medication is dispensed, I understand that I must provide a written authorization which includes the date to be administered, my child's name, name of the medication, prescription number, dosage and the time to be administered. All medicine will be in its original package. I further understand that the Center does not administer Inhalers unless the child's doctor has specified the amount to be inhaled and the time of day to be administered.

Release from Center

I agree that my child will not be allowed to enter or leave the Center without being escorted by the parent(s); person(s) authorized by parent(s) or Center personnel. Any person other than the parent or Center Staff must be stipulated in the child's application.

Notification of Address and Important Information

I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they may occur, telephone numbers, work location, emergency contacts, child's physician, health status, feeding plans, immunization records, etc.

Incidents

I understand that it is Gems' policy to keep me informed of any incidents, including illness, injuries, adverse reactions to medicines, and exposure to communicable diseases to which my child may be exposed. If the Center informs me that my child is ill, I understand that I must pick my child up within 40 minutes from being called.

Transportation

Gems will also obtain written authorization from me before my child participates in routine transportation, field trips, or special activities away from the Center including water related activities that are more than two feet deep.

Termination from Center

Gems has the right to terminate my child if it is agreed and determined that the Center is not the best environment for my child's development or if they cannot meet my child's needs.

_____ Date _____ 20___

Signature of Parent/Guardian

GEMS LEARNING ACADEMY

Emergency Medical authorization

Should_____, who was born on _____, suffer an injury or illness while in the care of GEMS LEARNING ACADEMY and the facility is unable to contact me immediately, 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 (we) 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's Name Telephone Number

Known Medical Conditions (diabetic, asthmatic, drug allergies)

_____ _____

_____ _____

_____ _____

Signed _____

Parent/Legal Guardian

Date _____

Telephone Numbers: _____Home

_____Work

_____Cell

Child's Physician or Health Care Provider

Name of Doctor_____

Address_____

Number Street City State Zip Code

Phone_____ Doctor's Name_____

The following special accommodations may be required to meet my child's needs while at the GLA

_____

_____

Describe any allergies you child may have

_____

_____

Does your child take any medication on a routine basis? _____ Yes _____ No

If yes please explain and list any medicines

_____

_____

I understand that there is a $1.00 per minute, per child, late fee assessed for each minute that I am late picking up my child after 6:30pm if he or she is on the normal drop-off schedule. The time is assessed according to the Academy's time clock which parents should synchronize their time with when dropping off their child

I further understand that my child's tuition is due on MONDAY of each week. If the tuition is not paid by Monday evening at 6:30pm, there will be a late fee of $30.00 charged and I cannot drop my child off on Tuesday if the tuition is not paid. If my child is absent for a week or more, he or she will be released from the Center, meaning that we cannot guarantee their slot unless arrangements were made in advance with the Director or his designee. I agree to pay for the Full Week if my child is present One Day during the week. I agree to pay One-Half tuition to reserve my child's slot if he or she is absent for an entire week.

Signature of Parent/Guardian_____

Date_____

GEMS Learning Academy does not discriminate on the basis of race, sex, age, disability, health, religion, or national origin. Children with persistent health or other challenges will be required to provide a physician's statement that their condition is satisfactory for full participation in the program. The

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

_____ DOB_____ RACE_____

(NAME OF CHILD)

_____

(Name of Facility)

_____

(Address of Facility)

My child is normally in attendance at the facility between the hours of _____am/pm to ____am/pm on the following days (circle applicable days):

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care (circle applicable meals/snacks)

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Beginning on _____

(Month/Day/Year)

_____ _____

Signature of Parent/Guardian Date

_____ _____

Center Signature Date

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

Child Adult Care Food Program

Income Eligibility Statement

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

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A: **A. Name** (List everyone in household, including foster and non-foster children)	**B. Gross income and how often it is received** Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				**C. Check if NO income**
	1. Earnings from work before deductions	**2. Welfare, child support, alimony**	**3. Social Security, pensions, retirement**	**4. All other income**	
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
6. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
7. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐

PART III: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm] on the following days:

☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

*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) listed on the form in Part I are enrolled for care .*

Signature: X_____ **Print Name** _____ **Date**_____

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

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

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Official Use Only: 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 ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: _____ Date withdrawn _____ Eligibility: Free _____ Reduced _____ Paid _____ Tier I _____ Tier II _____

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____days)

Determining Official's Signature: _____ Date_____

Confirming Official's Signature: _____ Date_____

Follow Up Official's Signature: _____ Date_____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.* Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced price meals.).

☐ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call _____ at _____

8850 High Point Road

Union City, Georgia 30291

(770)306-6133-Office

(770)306-6139-Fax

VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name_____ Date of Birth_____

(Last) (First) (Middle)

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email address_____

Mother's Name_____ Work Phone _____

Cell Phone_____ Email address_____

Father's Name_____ Work Phone_____

Cell Phone_____ Email address_____

PERSON TO NOTIFY IN AN EMERGENCY IF PARENTS CANNOT BE REACHED:

Name _____Phone_____

Child's Doctor _____Phone_____

Medical Facility used by GEMS: Southern Regional Medical Center, 11 upper Riverdale road, Riverdale, Georgia.

Child's Allergies_____

Current prescribed medicine_____

Child's special needs and conditions_____

In the event of an emergency and the Center cannot get in touched 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

Childs Name_____

Signature (Parent/Guardian) _____

Witness by_____ Date_____

GEMS LEARNING ACADEMY

8850 High Point Road