Child's Name: _____

Date of Birth: _____ Date Enrolled: _____

2024 Check List

Please fill out the following and return at least 2 working days before the Start Date for your child.

- GEMS Enrollment Application
- Emergency Medical Form
- Parental Agreement
- Allergy Statement (Allergies must be noted during enrollment)
- Emergency Contact List
- Authorized persons pickup list
- Copy of Guardians Identification
- All USDA forms
- Immunization form (3231 Form)
- Parent Handbook with detailed policies and procedures (emailed upon enrollment)

Date Completed: _____

Reviewed By: _____ _____

Print Name Signature

8850 High Point Road
Union City, GA 30291
770-306-6133

Enrollment Application (Please Print Clearly)

Entrance Date: _____ Withdrawal 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: _____

Child's Living arrangements: ___ Both Parents ___Mother ____Father _____ Other

Chil's Legal Guardian: _____ Both Parents ____ Mother ____ Father _____ Other

Parent Authorizes Gems Learning Academy 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: _____
Number Street City State Zip Code

Phone: _____ Alternate Phone: _____

Relationship to Child/Parent_____

Name: _____

Address: _____
Number Street City State Zip Code

Phone: _____ Alternate Phone: _____

Relationship to Child/Parent _____

In the case of an emergency who other than the parent may we contact:

Name: _____

Address: _____
Number Street City State Zip Code

Phone: _____ Alternate Phone: _____

Relationship to Chil/Parent _____

My Child Attends the Following School (if Applicable)

Name of School_____

Address_____

Phone _____ Teacher's Name: _____

Parental Agreement

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 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 a specified the amount to be inhaled and the time of the 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 at 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 Gem's 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 of 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.

Late pick up Policy

There is a $5.00 per minute per family late fee assessed for every minute the parent/guardian is late picking up his or her child. Hours of operation is 6:00am-6:30pm. The time assessed is according to Gem's Learning Academy's time clock.

Tuition and Fees

Tuition and fees are due on Monday of each week. If tuition is not paid by Monday evening at 6:30 pm, there will be a late fee of $20.00 charged and If payment is not made by Tuesday afternoon, then child/ren will not be able to attend on Wednesday. I agree to pay full tuition to reserve my child's slot if he or she is absent for an entire week.

Return Check Policy

Bounced checks incur a $25.00 return check fee and your child will not be able to attend the center until payment is paid in full. Method of payment should be with a money order or pay with a credit card online.

School Closing Policy

Gem's will be closed on the following days: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Juneteenth, Thanksgiving Day and the day after, Christmas Eve, Christmas Day, New Year's Eve (Closes at 2:00 pm). Gems will close for inclement weather in accordance with Fulton County Schools.

Parent Handbook:

I have received and read the Parent Handbook for Gems Learning Academy. I understand the policies and procedures.

Signature of Parent/Guardian_____

Date: _____

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 Gems' Learning Academy:

_____

_____

Describe any allergies your child may have.

_____

_____

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

If yes, please explain and list any medications.

_____

_____

Signature: _____ Date: _____

GEMS Learning Academy does not discriminate of 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.

Transportation Agreement

This is to certify that I give Gems Learning Academy
Name of Facility

Permission to transport my child _____
Name of Child

From Gem's Learning Academy at _____ (am/pm)
Pickup Location

To _____ at _____ (am/pm)
Delivery Location

My child will be transported from _____ at _____ (am/pm)

To Gem's Learning Academy at _____ (am/pm)
Delivery Location

On the following days:

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

_____ is authorized to receive my child. In the event the authorized
Name of Authorized Person

Person is not present to receive my child, the following procedures are to be followed:
_____
_____
_____

The _____ is approximately _____ miles from the center. In the event my child is not to be transported as outlined above, I agree to notify Gem's Learning Academy.

Signature (Parent/Guardian) _____ Date _____

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 Number: _____

Child's Doctor: _____ Phone Number: _____

Medical Facility used by Gem's Learning Academy: **Southern Regional Medical Center, 11 Upper Riverdale Rd. Riverdale, Ga. 30274**

Child's Allergies: _____

Current Prescribed Medication: _____

Child's Special needs and conditions: _____

In the event of an emergency and the center 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: _____

Allergy Statement

Child's Name: _____

Parent's Name: _____

Nature of Allergy: _____

Foods Child is Allergic to:	Substitute Foods:
_____	_____
_____	_____
_____	_____
_____	_____

Health Care Practitioner: _____
(Print Name) (Title)

Address: _____

_____

_____

_____
Signature of Healthcare Provider

_____
Date

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Bright from the Start: Department of Early Care and Learning
Nutrition Services (Suite 754)
2 Martin Luther King, Jr. Dr., SE Atlanta, GA 30334
404-656-5987
www.decal.ga.gov

[Here is space for the sponsoring organization to add contact information]

Learn more about CACFP at USDA's website: https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro con CACFP

Esta guardería infantil recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.

Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.

¿Preguntas? ¿Inquietudes?

Bright from the Start: Department of Early Care and Learning
Nutrition Services (Suite 754)
2 Martin Luther King, Jr. Dr., SE Atlanta, GA 30334
404-656-5987
www.decal.ga.gov

[Here is space for the sponsoring organization to add contact information]

Aprenda más información sobre CACFP en el sitio web del USDA: https://www.fns.usda.gov/

USDA es un proveedor, empleador y prestamista que ofrece igualdad de oportunidades.

United States Department of Agriculture
Food and Nutrition Service FNS-317
Noviembre 2019

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 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 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? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **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:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ 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: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits on the Annual Income Eligibility Guidelines.

Household Size	Yearly Income
1	**Please refer to the Income Eligibility Guidelines that are updated annually and available at https://www.decal.ga.gov/documents/attachments/Incomeeligibguidelines.pdf**
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 SNAP, 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

SHARING INFORMATION WITH MEDICAID/SCHIP

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 _____

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.

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, 2023 to June 30, 2024)

Household Size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	26,973	2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
For each additional family member add	+ 9,509	+793	+ 397	+366	+ 183