HERITAGE HILLS EARLY LEARNING CENTER
CHILDREN'S ENROLLMENT FORM

Entrance Date: _____ Withdrawal Date: _____

Child's Name	M/F Sex	Age	Birthdate

Home Address Home Telephone Number

Father's Name/Home Address/Telephone Number/Cell Number

Father's Place of Employment/ Address of Employment/Business Number

Mother's Name/Home Address/Telephone Number/Cell

Mother's Place of Employment/Address of Employment/Business Number

Child's Living Arrangements: ( ) Both Parents ( ) Mother ( ) Father ( ) other

Child's Legal Guardian(s): ( ) Both Parents ( ) Mother ( ) Father ( ) other
Child's Siblings: None ( )

Brother: 1._____

2._____

Sister: 1._____

2._____

EMAIL ADDRESS: _____

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

Name, Address (complete street address, city, state, and zip code) and relationship to child.

- ***Everyone must show ID before a child will be released to them***

1. _____

2. _____

3. _____

4. _____

- Please use another sheet of paper if necessary.

Person's to contact in case of an emergency when parents can't be reached:

Name	Relationship to child	Telephone Number	Cell
1.			
2.			
3.			
4.			

Name of public or private school child attends if any:

_____

MEDICAL INFORMATION

Child's Physician or Clinic's Name (Child's Primary Health Source)

_____

Physician/Clinic's Telephone: _____

My child has the following special need(s): NO YES (see below) (circle one)

_____

_____

The following special accommodation(s) may be required fo most effectively meet my child's needs while at the Learning Center.

NONE **Yes (see below)** **(circle one)**

_____

_____

ALLERGIES

My child has the following: **None** **Yes (see below)** **Food Allergies**

(Please circle one)

_____

_____

_____

_____

MEDICATIONS

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:

NONE YES (see below) (circle one)

_____

_____

_____

_____

_____

- **PLEASE NOTE: A MEDICATION FORM MUST BE FILLED OUT EVERY TEN DAYS BY A PARENT OR LEGAL GUARDIAN.**

EMERGENCY MEDICAL AUTHORIZATION

Should _____ _____
Child's Name Date of Birth

Suffer an injury or illness while in the care of Heritage Hills Early Learning Center 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 agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

_____

Signature of Parent/Guardian Date Telephone

_____

Signature of Preschool Director Date

HEALTH AND SOCIAL RECORD

Child's Name _____ Birthdate _____

Has your child ever been in a childcare setting? ☐ Yes ☐ No
If so, what kind? ☐ Relatives care ☐ in home ☐ Church ☐ other _____

Briefly describe your child's
experience _____

Does your child have an existing condition of which we need to be aware?
☐ Yes ☐ No Explain:

_____

_____

Is your child fully able to participate in all of the activities offered by Heritage Hills Learning Center? ☐ Yes ☐ No
Explain: _____

Does your child function at the appropriate age level? ☐ Yes ☐ No
Explain: _____

Does your child walk? ☐ Yes ☐ No Explain:

_____

Can your child effectively communicate his/her needs? ☐ Yes ☐ No
Explain: _____

Is your child on a special or restricted diet or have any food allergies (i.e. peanut butter)? ☐ Yes ☐ No Explain:

_____

Does your child have any non-food allergies of which we should be aware?
☐ Yes ☐ No Explain:

_____

Does your child have any problems at mealtime? ☐ Yes ☐ No Explain:

Does your child rest in the middle of the day? ☐ Yes ☐ No

Is your child toilet trained? ☐ Yes ☐ No if yes does she/he need assistance? ☐ Yes ☐ No

Does your child require any medication, medical treatment or assessment while in childcare? ☐ Yes ☐ No Explain:

Does your child use any special equipment such as a breathing machine, wheelchair, hearing aid, braces, etc.? ☐ Yes ☐ No

Does your child require one-on-one supervision on a regular basis for a significant period of time? ☐ Yes ☐ No Explain:

Does your child require and/or desire any accommodations or modifications in order to fully and equally enjoy and participate in Heritage Hills Early Learning Center's group setting? ☐ Yes ☐ No Explain:

Heritage Hills Early Learning Center
Student Photo and Work Release Form

Within Heritage Hills Baptist Church we share newsworthy and notable events that happen in our classes with the community at large and within the church. To publicize school and /or student achievements, we like to publish student art, literary, and audio/video productions, which may or may not include your child's photograph.

When using a student's name, it is our general practice to use first names only. In the event that two students have the same first name, the last initial will be included. There are some occasions when it is necessary to use both first and last names. We will NOT publish home addresses, telephones numbers or personal e-mail addresses.

Should your child's work be chosen for publication, your signature on this form acknowledges your permission for such work to reproduce.

Please return this form to your child's teacher

_____ Yes _____ No My child's work and image (photography) may be displayed.

Exceptions: _____

I hereby give Heritage Hills Early Learning Center permission and release the Church from any liability resulting from or connected with the publication of my child's work or photograph as outlined above.

Child's Name: _____ Teacher: _____

Parent Name: _____ Date: _____

Parent/Guardian Signature: _____

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)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

Early Learning Center

HERITAGE HILLS BAPTIST CHURCH

Dear Parents,

As you know we are a non- profit child care center. As a way to better serve your children we are applying for the Federal Food Program for the Early Learning Center. This will allow us to include more fresh fruits and vegetables in our daily menus. In order to complete our application we have to a completed Income Eligibility Statement from each family. These statements are completely confidential and are used to help me determine how to classify each student (you only have to complete one form per family). We will update these forms on a yearly basis. Your cooperation is greatly appreciated. I am including an instruction sheet to explain how to fill the form out. If you have any question, please feel free to contact me at the center.

Thank you,

Lisa Dawkins, Preschool Director
770-289-2294
770-922-2027 ext. 33
ldawkins@hhbcga.org

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.

INSTRUCTIONS

Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children.**

Part II: Skip this part.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: Sign the form. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.

Part II: To report total household income from last month, complete the following:

Column A-Name: List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you (including foster and non-foster children). In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary.

Column B-Gross Income last month and how often it was received: Next to each person's name, list each type of income received last month, and how often it was received.

Box 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

Box 2: List the amount each person got last month from welfare, child support, alimony.

Box 3: List Social Security, pensions, and retirement.

Box 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C-Check if no income: If the person does not have any income, check the box.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must sign the form, and list the last four digits of his/her social security number. Or, mark the box if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

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 **[name]** at **[phone]**

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, 2016 to June 30, 2017)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	21,978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member add	+ 7,696	+ 642	+ 321	+ 296	+ 148