Avant Learning Academy

Entrance Date_____ Withdrawal Date_____

Child's Name_____ Sex___ Age_____ Date of birth_____

Home Address (Street)_____

City_____ State_____ Zip_____

Home Phone Number_____

Father's Name_____ Home Phone Number_____

Email Address_____

Father's Home Address (if different from child's) Street_____

City_____ State_____ Zip_____

Father's Place of Employment_____ Work Phone _____

Employer's Street Address_____ City_____ State_____ Zip_____

Mother's Name_____ Home Phone Number_____

Email Address_____

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_____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

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

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____ Telephone Number_____
Relationship to child_____

Name_____ Telephone Number_____

Relationship to child_____

Name_____ Telephone Number_____

Relationship to child_____

Name of Public or Private School child attends, if any:_____

Child's doctor or clinic name_____

Doctor/clinic phone #_____

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:_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____ Date of birth_____
suffer an injury or illness while in the care of (Facility name)_____
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:_____

Parental Agreements with Child Care Facility

The Avant Learning Academy agrees to provide childcare for
(Name of Facility)
_____ on Monday-Friday 6 a.m. to 6 p.m.
(Name of Child) (Days of Week)
from January to December .
(Month) (Month)

My child will participate in the following meal plan:

Breakfast
Lunch
Afternoon 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.

Avant Learning Academy 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 childcare 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
Avant Learning Academy .
(Name of Facility)

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 Administrator/Person-In-Charge)

Permission to Photograph and Film

I give Avant Learning Academy permission to photograph, film, videotape, and/or audio record my child. I understand that said visual or audio recordings may be used by television stations, radio stations, print media, and/or Avant Learning Academy itself in any of the various publications, displays, and/or exhibits.

_____

Child's Name

_____

Signature of Parent/Guardian

_____

Date

Safe Sleep Practices Policy

Child's name:_____ Date of birth:_____

Parent/Guardian name:_____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:
Change and launder bedding daily/weekly. Bedding will be marked for individual use.

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?_____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula)_____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods_____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

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

Authorization for Medication

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____

Amount of Medication to be given: _____

Dates to be given: _____

_____ _____

Signature of Parent/Guardian Date

FOR CENTER USE ONLY

Date	Time Given	Amount	Any Adverse Reactions	Administered By

Medication forms are only to be used two weeks at a time. The state requires that ALL lines be filled in and specific information must be given. Terms such as "as needed" will cause us to be cited by Bright From the Start. An entry for each date must be made even if the child was absent for the day.

Avant Learning Academy does not give over the counter medication.

Noticeable adverse reaction to medication what action was taken? Describe.

_____

_____

_____

_____

_____

_____

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother'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 Memorial Health University Medical Center

Address 4700 Waters Ave Savannah, GA 31404

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Avant Learning Academy 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 _____

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? $_____/_____

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. 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:	Check (✓) one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ 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 ☐ 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**: _____