INSPIRING SCHOLARS ACADEMY STUDENT FILE CHECKLIST

The following forms must be in each child's file if applicable. Place a check mark or *N/*A for each completed form on file.

- __ Registration fee
- __ Enrollment forms
- ___ Form 3231 (Immunization certificate)
- __ Birth Certificate

Inspiring Scholars Academy is licensed by Bright from the Start: the state of Georgia Licensing Agency. As such, these forms are required as part of the guidelines of the state. Each form must be completed in its entirety or the enrollment will not be accepted.

Child Name (s): _____

Date of Enrollment:_____

Start Date:_____

I.D. #_____

Inspiring Scholars Academy

2345 Pope Rd Douglasville, GA 30135

7425 Bank Head Hwy

Winston GA 30187

CHILD'S INFORMATION (Please print name as it appears on the birth certificate)

1. CHILD'S Name:

CHILD'S D.0.B. (MM/DD/BY): SEX: [ ] M [ ] F GRADE:

HOME ADDRESS: COUNTY:

CITY: STATE: ZIP:

HOME PHONE: ( )

COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No

Drop off Time:

Pick-up Time:

2. CHILD'S Name:

CHILD'S D.0.B. (MM/DD/BY): SEX: [ ] M [ ] F GRADE:

HOME ADDRESS: COUNTY:

CITY: STATE: ZIP:

HOME PHONE: ( )

COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No

Drop off Time:

Pick-up Time:

3. CHILD'S Name:

CHILD'S D.0.B. (MM/DD/BY): SEX: [ ] M [ ] F GRADE:

HOME ADDRESS: COUNTY:

CITY: STATE: ZIP:

HOME PHONE: ( )

COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No

Inspiring Scholars Academy

PARENT/GUARDIAN INFORMATION:

MOTHER'S NAME:

HOME ADDRESS (If different from child):

CITY: STATE: ZIP:

HOME PHONE ( ) WORK. PHONE ( )

EMAIL ADDRESS:

PLACE OF EMPLOYMENT:

ADDRESS : COUNTY:

CITY: STATE: ZIP:

FATHER'S NAME: ·

HOME ADDRESS (If different from child):

CITY: STATE: ZIP:

HOME PHONE) WORK. PHONE ( )

(EMAIL ADDRESS:

PLACE OF EMPLOYMENT :

ADDRESS: COUNTY:

CITY: STATE: ZIP:

EMERGENCY CONTACT INFORMATION (Person to contact in the event that either parent/guardian cannot be contacted. Add additional contacts on back)

1.) NAME: DAY TIME PBONE: ( )

DAY TIME ADDRESS:

CITY: STATE: ZIP: .

2.) NAME: DAY TIME PBONE: ( )

DAY TIME ADDRESS:

CITY: STATE: ZIP: .

Inspiring Scholars Academy

CHILD'S INFORMATION

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:

1. NAME:

ADDRESS:

RELATIONSHIP:

2. NAME:

ADDRESS:

RELATIONSHIP:

3. NAME:

ADDRESS:

RELATIONSHIP:

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:

_____ I UNDERSTAND A MEDICAL AUTHORIZATION FORM MUST BE COMPLETED GIVING INSPIRING SCHOLARS ACADEMY STAFF PERMISSION TO ISSUE MEDICATION TO MY CHILD. (Please initial)

Inspiring Scholars Academy

Physicians Name _____

Physicians Number_____

PARENTAL AGREEMENT INTIAL

____ NO CHILD WILL BE ALLOWED TO ENTER OR EXIT THE CENTER WITHOUT A PARENT OR A PERSONS AUTHORIZED BY THE PARENT.

____ YOU (THE PARENT) ARE RESPONSIBLE FOR KEEPING THE CENTER ADVISED OF SIGNIFICANT CHANGES AS THE CHANGES OCCUR IN THE INFORMATION YOU (THE PARENT) PROVIDED AT THE TIME OF ENROLLEMENT. (PHONE NUMBERS, EMERGENCY CONTACTS, ETC....)

____ YOU (THE PARENT) HAVE RECEIVED A COPY OF THE CENTER'S PARENT HANDBOOK POLICY AND PROCEDURES BY EMAIL.

____ YOU (THE PARENT) WILL BE ADVISED OF YOUR CHILD'S PROGRESS.

I AUTHORIZE INSPIRING SCHOLARS TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD WHEN I'M NOT AVAILABLE AND I WILL NOT HOLD INSPIRING SCHOLARS RESPONSIBLE FOR ANY OF THE MEDICAL BILLS OR TRANSPORTATION FEES THAT OCCUR.

Parent/Guardian

Signature:_____Date_____

Inspiring Scholars Academy

FEE AGREEMENT

All custodial parents and/or legal guardians are required to sign a Fee Agreement prior to enrollment of their child in **Inspiring Scholars Academy**. Parents are required to indicate to whom all billing information and correspondence is to be addressed. Please read and initial this agreement.

____ (**Initial)** I understand Inspiring Scholars Academy will charge a $36.00 fee for tuition checks returned by the bank. Returned tuition checks will not be re-deposited.

____ (**Initial**) I understand Inspiring Scholars Academy will charge a **2%** service fee for credit card and PayPal payment.

____ (Initial) I understand payments are due on Fridays for the following week of care**.**

____ (Initial) I understand Inspiring Scholars Academy will charge a **$25.00** late fee if payment is not received by pick-up Monday.

____ (**Initial**) I understand tuition is not prorated and is due in full whether or not my child attends Inspiring Scholars Academy.

____ (**Initial**) I understand there is no credit/reimbursement given for scheduled school holidays, child illness, children with behavior issues, or for closings due to emergency situations, or inclement weather.

_____ (**Initial**) I understand non-payment of tuition is grounds for immediate dismissal from Inspiring Scholars Academy.

____ (**Initial**) I understand Inspiring Scholars Academy charge a **$1.00** per minute late fee after agreed pick-up time.

Children are allowed one week of vacation per calendar school year. Parents must provide a two week notices. If a notice is not provided, parents will be responsible for weekly payment.

Parent Name: _____

Parent Signature: _____

Email Address: _____

Contact Number: _____

Inspiring Scholars Academy

PHOTOGRAPH/VIDEOTAPE RELEASE

_____I hereby grant permission for Inspiring Scholars Tutoring, which shall include, but not be limited to, the Georgia Department of Education, to record the participation and appearance of my child, _____, child_____, child_____by photograph and/or videotape in connection with daily tutoring activities for the purposes of news releases, reporting, and assessing the progress of children and the program. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for Inspiring Scholars Tutoring and/or on Inspiring Scholars Tutoring web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and Inspiring Scholars Tutoring, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child. This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

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 arent.

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)

Other (please specify):

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

MEAL BENEFIT INCOME ELIGIBILITY FORM

Name of Child Care Center: Inspiring Scholars Academy Provider: _____

Part I. Child/Children enrolled to receive child care:

Name: (First, Middle Initial, Last)	**Date of Birth (Optional)** MM/DD/YY	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: Name (List everyone in household, including foster and non-foster children)	**B. Gross income and how often it was received**				
	1. Earnings from work before deductions	**2. Welfare, child support, alimony**	**3. Social Security pensions, retirement**	**4. All Other Income**	**C. Check if NO Income**
(Example) Jane Smith	$ 200/week	$ 150/twice a month	$ 100/month	$ /	☐
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 6[am/pm] to 7 [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 Last Four Digits of 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 the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this 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 purposely 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.*

Sign here:_____ **Print name:**_____ **Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____ **Phone Number:**_____

Part V. Participant's ethnic and racial identities (optional)

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

Don't fill out this part. This is for 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____ Denied____ Tier I_____ Tier II_____
Reason:_____
Temporary: Free_____ Reduced_____ Time Period:_____ (expires after_ days)
Determining Official's Signature:_____ Date:

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)

Inspiring Scholars Academy
2016-2017
OBSERVE HOLIDAYS

September 5, 2016
November 24-25, 2016
December 23-26, 2016
January 2, 2017
January 16
April 14, 2017*
May 29, 2017
July 4, 2017

*Exclude ASP