INSPIRING SCHOLARS ACADEMY 2025/2026 STUDENT FILE CHECKLIST

Inspiring Scholars Academy LLC is licensed by Bright from the Start: the state of Georgia Licensing Agency for Daycares. 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 <u>will not</u> be accepted.

Child Name (s): _____

Date of Enrollment: _____

Start Date: _____

---------- Office Only—----------

Place a check mark or N/A for each completed form on file.

_____ Registration Fee

_____ Completed Enrollment Forms

_____ Form 3231 (Immunization certificate for non- school age children)

_____ Birth Certificate

_____ Driver' s License

_____ Tuition Express

Registration $100 Pd Y N

Staff Receiving Application : _____

2025-2026 Application
Inspiring Scholars
Academy
13671 Veterans Memorial Hwy Winston, GA 30187

CHILD'S INFORMATION (Please print name as it appears on the birth certificate)		
CHILD'S LEGAL GUARDIAN: [ ] BOTH PARENTS [ ] MOTHER [ ] FATHER [] OTHER		
1.CHILD'S NAME:		
CHILD'S D.0.B. (/ /): **SEX: [ ] M [ ] F** **AGE:**		
HOME ADDRESS:	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No		

CHILD'S INFORMATION (Please print name as it appears on the birth certificate)		
CHILD'S LEGAL GUARDIAN: [ ] BOTH PARENTS [ ] MOTHER [ ] FATHER [] OTHER		
2.CHILD'S NAME:		
CHILD'S D.0.B. (/ /): **SEX: [ ] M [ ] F** **AGE:**		
HOME ADDRESS:	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No		

PARENT/GUARDIAN INFORMATION:		
MOTHER'S NAME:		
HOME ADDRESS: (If Different From Child)	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
PHONE:	**Email Address:**	
WORK PHONE:		
Copy of License Yes or No		

PARENT/GUARDIAN INFORMATION:		
FATHER"S NAME:		
HOME ADDRESS: (If Different From Child)	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
PHONE:	**Email Address:**	
WORK PHONE:		
Copy of License Yes or No		

EMERGENCY CONTACT INFORMATION (Person to contact in the event that either parent/guardian cannot be contacted. Add additional contacts on back)
1. CONTACT NAME:
CONTACT NUMBER:
EMERGENCY CONTACT INFORMATION (Person to contact in the event that either parent/guardian cannot be contacted. Add additional contacts on back)
2. CONTACT NAME::
CONTACT NUMBER:
AUTHORIZED PICK-UP THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:
1. CONTACT NAME::
CONTACT NUMBER:
2.CONTACT NAME:**:**
CONTACT NUMBER:

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRE TO MOST EFFECTIVELY MEET MY CHILDS NEEDS WHILE AT THE CENTER_____

MY CHILD HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS OR HEALTH CONCERNS: _____

MY CHILD IS CURRENTLY ON THE FOLLOWING MEDICATIONS_____

___(Initial) I UNDERSTAND A MEDICATION AUTHORIZATION FORM MUST BE COMPLETED GIVING INSPIRING SCHOLARS ACADEMY STAFF PERMISSION TO ISSUE MEDICATION TO MY CHILD (ONLY LIFE SAVING MEDICATIONS)

CHILDS MEDICAL DOCTOR

If you do not have a doctor, please refer to:

Douglas County Health Center: 770-949-1970

PHYSICIANS NAME _____

PHYSICIANS NUMBER_____

PARENTAL AGREEMENT INITIAL

____NO CHILD WILL BE ALLOWED TO ENTER OR EXIT THE CENTER WITHOUT A PARENT OR A PERSON AUTHORIZED BY THE PARENT(OVER 18)

____YOU ARE RESPONSIBLE FOR KEEPING THE CENTER ADVISED OF UPDATED CHANGES. (PHONE NUMBERS, EMERGENCY CONTACTS, ETC)

____YOU HAVE RECEIVED A COPY OF THE CENTER'S PARENT HANDBOOK POLICY AND PROCEDURES BY EMAIL.

____YOU 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.

Signature (Parent/Guardian)_____Date_____

FEE AGREEMENT (INITIAL EACH LINE)

All custodial parents and/or legal guardians are required to sign a Fee Agreement prior to enrollment at **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 **$5** service fee for check and money orders

_____(**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 that Inspiring Scholars Academy does not accept cash

_____**(Initial)** I understand **payments are due Fridays** before the week of service.

_____**(Initial)** I understand my child will not be permitted to attend the following week without full payment.

_____**(Initial)** I understand Inspiring Scholars Academy will charge a **$25.00** late fee if payment is not received by close of business day Monday. *Late fees will be charged weekly on all accounts with outstanding balances no matter the enrollment status.*

_____**(Initial)** My child will not be able to attend until payment including late fees are made in full. Termination of services for non-payment does not eliminate the mandatory two-week notification for your child(s) withdrawal.

_____**(Initial)** Official notification for withdrawal from Inspiring Scholars requires a minimum of two weeks' notice in writing.

_____**(Initial)** I understand I will lose my sibling discount if my payment is late twice (2 times) within a school year.

_____(**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 Inspiring Scholars Academy charges a **$1.00** per minute per child late fee after agreed pick up time.

_____**(Initial)** I understand my child has to be in school by 9:30 am or have a Doctor's excuse to sign in.

_____**(Initial)** I acknowledge that Inspiring Scholars charges $100 for annual school registration.

_____**(Initial)** Delinquent accounts sent to collections will be charged a 30% collection fee in addition to the remaining balance.

_____**(Initial)** I understand my child can remain under our care for up to 10 hours per day.

_____**(Initial) Tuition Express** I understand and agree that any outstanding balance that is owed at the time of ending services will be deducted automatically from the information given on the Tuition Express form.

_____**(Initial) CAPS Clients Only** I understand that if I do not sign my child in/out daily, I will be charged full weekly payments for my child(s).

_____**(Initial) Daycare Only**. Children are allowed one week of vacation per calendar school year. Parents must provide a two-week notice in advance of vacation. If a notice is not provided, parents will be responsible for weekly payment.

Parent Name: _____

Parent Signature: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for Inspiring Scholars Academy, which shall include, but not be limited to, the Georgia Department of Education, to record the participation and appearance of my child (1), _____, child (2)_____, child(3)_____by photograph and/or videotape in connection with daily 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 Academy and/or on Inspiring Scholars Academy website.

The undersigned hereby jointly and severally releases, acquits, forgives, Inspiring Scholars Academy, 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 the law.

Signature: _____**Date**: _____

Food Allergy Action Plan

Student's Name:_____D.O.B:_____

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 area 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™0.15mg

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 _____

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 the 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.

_____Bandaids
_____Bactine or similar first aid spray
_____Neosporin or similar ointment
_____Bactine or similar first aid spray
_____Sunscreen(parent must supply)
_____Non-Prescription ointment (such as A & D: Desitin, Vaseline)
_____Other (please specify):

Signature: _____**Date**: _____

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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**: _____

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Tuition Express®

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – an automatic payment processing system that allows on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ ☐ **to initiate credit card charges to the below referenced credit card account (Section A) OR,** ☐ **initiate debit entries to my (our) Checking or Savings Account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

SECTION A

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____

☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature

A service of procare SOFTWARE®

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(Parent Copy)

Daycare Hours 6:00am-6:00pm (max 10 hrs.)
9:30am is the latest a child can be dropped off without a Doctor, Dentist, or WIC letter. **Breakfast ends @ 8:30am**

Late Pick-up: 1st occurrence $1 per minute per child, 2nd occurrence $3 per minute per child, 3rd occurrence $5 per minute per child and possibly withdrawn.

Tuition: Payment is due Friday and child cant be dropped off on Monday without full payment

Check fee: There is a $5 service fee for checks and money orders. Cash not accepted
Returned check fee: $36

Late Fee: $25 late fee if payment is not received by 6 pm Mondays'. Late fees will be charged weekly on all accounts with outstanding balances enrolled/unenrolled status.

Non Payment: Services will be suspended until full payment is made including late fees. Termination of services for non-payment does not eliminate the mandatory two week notification of your child(s) withdrawal.

The sibling discount benefit will be discontinued if there are 2 consecutive late payments of tuition.

A written **2-week notice** is required to terminate service offered by Inspiring Scholars.

Refund Policy: No refunds will be given.

Sign-In and Sign-Out: Only adults listed on the "authorized pick-up list" section of the Registration Form with photo ID will be permitted to pick-up your student. Please be sure to include anyone that you may want /need to pick-up your student on the registration form.

Personal Items: Students should not bring toys, electronic devices or unsecured personal items. Inspiring Scholars will not be held liable for any lost and/or damaged items.

Medication: We have a NO MEDICATION policy. Exceptions may be made for life sustaining medication. If accepted, a consent form must be filled out and put on file.

Water Bottle: Is mandatory daily **$1 Daily Water Bottle Fee-** If your child doesn't have one each day.

Outside food is not allowed

Inspiring Scholars Academy

OBSERVED HOLIDAYS
2025-2026

CLOSED

September 1 2025- Labor Day

November 27-28 2025 - Thanksgiving

December 24-25 2025- Christmas Eve/Day

January 1 2026 - New Years

January 19 2026- Martin Luthern King

April 3 2026 - Good Friday

May 25 2026 - Memorial Day

June 19 2026 - Juneteenth

July 3rd 2026- Independence Day