

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

Name _____ Phone #(s) _____

Name _____ Phone #(s) _____

Name _____ Phone #(s) _____

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: _____

London's Little Angels 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 _____

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 _____

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) _____

Parental Agreements with Child Care Facility

The _____ agrees to provide day care for
 _____ (Name of Facility)
 _____ on _____ a.m. to _____ p.m.
 _____ (Name of Child) (Days of Week)
 from _____ to _____
 _____ (Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Evening Snack
- Dinner
- Bedtime 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.

The Little Angels Learning 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 child care 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

Little Angels Learning
(Name of Facility)

I understand that the center 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)

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 Atlanta Medical Center (South Fulton)

Address 1170 Cleveland Ave East Atlanta Ga 30314 (404) 412-1111

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if London Little Angels Learning Acad
Name of Facility

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 FDIPIR 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
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Income¹ - Sometimes children in the household earn or receive income. Please indicate the TOTAL Child Income/How often? income received by child household members listed in PART I here. \$ _____ / _____

B. Other Household Members¹ List all household members (including yourself) not listed in Part I even if they do not receive income. 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: _____

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
 Hispanic/Latino Not Hispanic/Latino

Check (✓) one or more racial identities:
 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 Month Year Household Size: _____

Categorical Eligibility: check (✓) if applicable Eligibility: check (✓) one Free Reduced Paid-Denied

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: _____