APPLICATION & CONTRACT

Child's Name: _____ _____
Last Name First Name

PARENT / GUARDIAN 1:

Account Name (Parent/Guardian 1): _____
DOB: _____
SSN (Parent/Guardian 1): _____ – _____ – _____
Email Address: _____
Relationship to Child: _____
Address: _____
Cell Number: _____ Home Number: _____
Employer: _____ Work Number: _____
Employer Address: _____

PARENT / GUARDIAN 2:

Account Name (Parent/Guardian 2): _____
DOB: _____
SSN (Parent/Guardian 2): _____ – _____ – _____
Email Address: _____
Relationship to Child: _____
Address: _____
Cell Number: _____ Home Number: _____
Employer: _____ Work Number: _____
Employer Address: _____

CHILD INFORMATION

Child's Primary Residence: ☐ BOTH ☐ MOTHER ☐ FATHER ☐ GUARDIAN
If divorced, who has legal custody? _____
May the non-custodial parent pick up the child? ☐ YES ☐ NO
(Willoway Preschool must be provided with court issued custody that clearly describe the custody arrangements. Any person granted custody in such papers may pick up the child during the times that person has custody and may designate other persons to pick up the child at such times, unless court papers state otherwise.)

DOB: _____ Sex: _____
Child's SSN (non required): _____ – _____ – _____
Home Address: _____
City: _____ State: _____ Zip: _____

Please list all siblings and other people living in the home:

Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____
Name: _____ Relationship: _____ Age: _____

Please list any special family dates (birthdays, adoption dates, etc):

_____
_____
_____
_____

How did you hear about us?
(Check all that apply)

- ☐ Direct Mail
- ☐ Yellow Pages
- ☐ Drive By
- ☐ Fliers
- ☐ Billboard
- ☐ Saw Our Buses

Referred by: _____
Internet Site: _____

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RELEASE AUTHORIZATION

AUTHORIZATION FOR TRANSPORTATION

PROGRAM ASSIGNMENT

The child will be released only to the people on this application and the following persons:

PERSON 1

Name: _____

Address: _____

Phone Number: _____

Relationship to Parent: _____ Relationship to Child: _____

PERSON 2

Name: _____

Address: _____

Phone Number: _____

Relationship to Parent: _____ Relationship to Child: _____

PERSON 3

Name: _____

Address: _____

Phone Number: _____

Relationship to Parent: _____ Relationship to Child: _____

Enrolling Parent/Guardian Signature: _____

Please Print: _____ Date: _____

My child has permission to ride the Willoway Preschool Bus to and / or from (name of school): _____

Signature of Parent/Guardian: _____ Date: _____

Willoway Preschool will be open from _____ AM to _____ PM for children ages 6 weeks -12 years old.

My child will attend the following days and times:

☐ M ☐ T ☐ W ☐ Th ☐ F

from _____ AM / PM to _____ AM / PM

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PARENT AUTHORIZATION FORM

HEALTH AND MEDICAL INFORMATION

AUTHORIZATION TO DISPENSE EXTERNAL PREPARATIONS

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 the center permission to apply one or more of the following topical ointments/preparations to my child in accordance with the direction 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: _____

Child's Name: _____
Child's Physician/Group Name: _____
Physician's Phone #: _____
Physician's Address: _____
City: _____ State: _____ Zip: _____
Hospital Preference & Address: _____

_____

Emergency Contact (other than parents): _____
Address: _____
Phone: _____

Does your child have any allergies or special needs?

_____

_____

_____

Is your child potty trained? ☐ YES ☐ NO

Insurance Provider: _____
Member Number: _____ Name of Policy Holder: _____
Description of Coverage: _____

_____

I acknowledge that this center cannot be held liable in any way for accidents that occur on or off premises while my child is under the center's care.

Parent/Guardian Signature: _____ Date: _____

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INDIVIDUAL NEEDS REVIEW FORM

INDIVIDUAL NEEDS REVIEW FORM

This form helps us understand how to best support your child while ensuring a safe, nurturing environment for all children and educators at Willoway Preschool. Completion of this form does not guarantee enrollment. Enrollment decisions are made on an individual basis in alignment with licensing requirments set forth by Bright from the Start/Georgia Decal.

CHILD INFORMATION

Child's Full Name: _____

Date of Birth: _____

Requested Start Date: _____

Program/Classroom Requested: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name(s): _____

Phone Number: _____

Email Address: _____

UNDERSTANDING YOUR CHILD'S NEEDS

- ☐ My child has been diagnosed with or identified as needing additional support.
- ☐ My child has NOT been diagnosed with or identified as needing additional support.

If yes, please describe: _____

_____

Does your child receive outside services? (Check all that Apply)

- ☐ Speech Therapy
- ☐ Occupational Therapy (OT)
- ☐ Physical Therapy (PT)
- ☐ Behavioral Therapy
- ☐ Early Intervention/IFSP
- ☐ IEP through local school system
- ☐ Other:
- ☐ My child requires one-to-one or additional supervision.

If yes or unsure, please explain: _____

_____

HEALTH & SAFETY CONSIDERATIONS

- ☐ My child has medical conditions, allergies, or health needs requiring monitoring.
- ☐ My child does NOT have medical conditions requiring monitoring.

If yes, please describe: _____

_____

- ☐ My child requires medication or medical procedures during the school day.
- ☐ My child does NOT require medication or medical procedures.

If yes, please explain: _____

_____

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INDIVIDUAL NEEDS REVIEW FORM

COMMUNICATION & TRANSITIONS

How does your child communicate best? (Check all that apply)

- ☐ Verbal
- ☐ Limited Verbal
- ☐ Non-Verbal
- ☐ Visual Supports
- ☐ Other:

Known triggers, sensitivities, or transition challenges: _____

_____

SUPPORTING A STRONG START

What strategies or supports have been most successful for your child?

_____

_____

Is there anything else you feel is important for us to know?_____

_____

DOCUMENTATION (IF APPLICABLE)

- ☐ IFSP or IEP
- ☐ Behavior Support Plan
- ☐ Medical Care Plan
- ☐ Therapist Recommendations

ACKNOWLEDGMENT

I acknowledge that enrollment decisions are made on an individual basis and are dependent on Willoway Preschool's ability to meet my child's needs while maintaining appropriate supervision, staffing ratios, and safety standards.

Parent/Guardian Signature: _____

Date: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL AND FIRST AID

AUTHORIZATION FOR PHOTOGRAPHY

AGREEMENT TO PROVIDE ADDITIONAL FORMS

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ENROLLMENT & FINANCIAL POLICIES

I agree to pay an annual registration fee at the time of enrollment and again annually. This enrollment fee is non-refundable.

I agree to pay the weekly tuition fee in advance, on, or before close of business each Monday, without exception.

I understand if my school uses an automatic payment system, such as Tuition Express, participation is MANDATORY. I will be charged a handling fee if I choose not to participate.

I am aware that I will be charged a fee for late tuition.

I am aware that I will be charged a fee for late pick-ups.

I have received the Parent Handbook, containing additional policies and procedures.

The institution is an equal opportunity provider.

I understand that current rates are subject to change.

I am aware that a two week notice is required for withdrawals and failure to properly notify the center will result in being charged for the period of time that the notice wasn't given.

I am aware that the center is within its rights to collect any unpaid tuition, fees and collection or court costs associated with collection of these charges.

Parent/Guardian Name (print): _____
Parent/Guardian Signature: _____ Date: _____

I hereby authorize the staff and director representing the center to give consent for any and all necessary emergency medical and First Aid care to include transportation, if needed, for my child while he/she is in the center's custody.

Parent/Guardian Signature: _____ Date: _____

Permission (☐ is / ☐ is not) given for photography for publicity purposes to be sued in print promotions, email, or use on the company's website including social media sites.

Parent/Guardian Signature: _____ Date: _____

I agree to provide an up-to-date Immunization Record for my child within ten (10) days of enrollment in the preschool program.

I agree to provide a completed Income Eligibility Statement (provided) at the time of enrollment.

Parent/Guardian Signature: _____ Date: _____

INFANT FEEDING PLAN

INFANT FEEDING PLAN

Child's Full Name: _____ Date: _____

Date of Birth: _____

Does the child take a 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 Food
☐ Formula ☐ Other

What type of formula used, if applicable? _____

Amount and time of formula/breast milk to be give? _____ Date: _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

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

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? ☐ Yes ☐ No Parent Initials: _____

The child has reached the following developmental skills:

Can hold their head steady? ☐ Yes ☐ No

Opens mouth/leans forward in anticipation of food offered? ☐ Yes ☐ No

Closes lips around a spoon? ☐ Yes ☐ No

Transfers food from front of the tongue to the back and swallows? ☐ Yes ☐ No

Instructions for the introduction of solid foods: _____

_____

Food likes: _____

Food dislikes: _____

Allergies (including any premixed formula): _____

_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

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

_____

PARENT'S SIGNATURE: _____ DATE: _____

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TRANSPORTATION AGREEMENT

TRANSPORTATION AGREEMENT

This is to certify that I give _____
Name of Facility

permission to transport my child _____
Name of Child

from _____ at _____ ☐ AM ☐ PM
Pickup Location

to _____ at _____ ☐ AM ☐ PM.
Delivery Location

My child will be transported from _____ at_____ ☐AM ☐PM

to _____ at _____ ☐AM ☐PM
Delivery Location

on the following days:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

_____ is authorized to receive my child. In the event the
Name of Authorized Person
authorized person is not present to receive my child, the following procedures are to be followed:

_____

_____

_____

_____

_____

The _____ is approximately _____ miles from the
Location
center. In the event that my child is not to be transported as outlined above, I agree to notify the _____.
Facility

Signature (Parent/Guardian) _____ Date _____

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EMERGENCY MEDICAL INFORMATION

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: _____ Work Phone: _____

Child's Doctor: _____ Work Phone: _____

Medical facility that center uses: _____

Address: _____

Child's Allergies: _____

Current prescribed medication: _____

Child's special needs and conditions: _____

In an event of an emergency involving my child, and if _____
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 of Parent/Guardian: _____

Witness By: _____ Date: _____

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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:

_____

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_____

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Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, 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) Willoway Preschool 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.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

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

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

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**: _____

Follow Up Official's Signature: _____ **Date**: _____