LATRENDAS WORLD FOR LEARNING
4025 VILLA AVENUE
MACON, GA 31204
(478) 405-7628

PLEASE READ THIS CONTRACT BEFORE SIGNING. IN ORDER TO PROVIDE YOU AND YOUR CHILD WITH THE TYPE OF CARE I FEEL IS BEST AND DESIRED: I BASE MY BUDGET ON ESTABLISHED ENROLLMENT. STAFF AND PAYROLL AND OVERHEAD EXPENSE CANNOT BE REDUCING BECAUSE OF ABSENTEE LOSSES OF INCOME. THIS CONTRACT IS BINDING AND WILL SUPPORT YOUR CHILD'S PLACE IN THE CENTER.

*THERE IS A SUPPLY FEE DUE TWICE A YEAR. THIS FEE IS $20.00, AND DUE MARCH 1, AND SEPTEMBER 1. THIS FEE GOES TOWARD SCHOOL SUPPLIES.

SERVING CHILDREN 6 WEEKS THROUGH 12 YEARS

*PAYMENT IS DUE ON MONDAY, IN ADVANCE OF THE WEEK. IF YOUR PAYMENT IS LATE THERE WILL BE A LATE FEE OF $5.00 A DAY. YOUR PAYMENT GOES TO PAY YOUR CHILD EXPENSES, WHICH I CANNOT PAY IF YOU DON"T. PAYMENT IS DUE IF YOUR CHILD COMES TO THE CENTER OR NOT.

DATES CLOSED

NEW YEARS DAY, MLK BIRTHDAY, PRESIDENT'S DAY, GOOD FRIDAY, MEMORIAL DAY FOURTH OF JULY, LABOR DAY, COLUMBUS DAY, THANKSGIVING DAY, (and day after) CHRISTMAS EVE, CHRISTMAS DAY.

RETURN CHECKS $30.00 as of June 1, 2005

I REQUIRE A TWO WEEK NOTICE OF WITHDRAWAL. THIS ALLOWS ME TIME TO REPLACE YOUR CHILD WITHOUT LOSS OF INCOME.

HOURS 7AM TO 12AM Rocky Creek & 7AM to 6PM Villa Ave. & Houston Ave.
*****LATE FEE FOR ANYONE FROM MORNING CARE AFTER 6PM*****
$1.00 EACH MINUTE AFTER 6 PM AND 12 AM. 'NO EXCEPTIONS'
I WILL CONTACT YOU IF YOUR CHILD HAS ANY OF THE FOLLOWING SYMPTOMS: FEVER, DIARRHEA, VOMITING, INJURY, EXPOSED TO COMMUNICABLE DISEASE, REACTION TO MEDICATION. IF YOUR CHILD HAVE A FEVER OF (101) DEGREE OR HIGHER TEMP. ANOTHER CONTAGIOUS SYMPTONS, SUCH AS, BUT NOT LIMITED TO A RASH OR SORE THROAT, DIARRHEA, HE/SHE WILL NOT BE ACCEPTED OR ALLOWED TO REMAIN AT THE CENTER.

****EACH CHILD MUST BE SIGNED IN AND OUT EACH DAY*****

YOUR CHILD MUST HAVE A CHANGE OF CLOTHES AT THE CENTER.
**** You will be called to bring your child his/her supplied if they are not here At the center when needed.**

EACH CHILD WILL HAVE THE BENEFIT OF OUTDOOR PLAY, EXCEPT IF INCLEMENT WEATHER. POLICY ON PROTECTION OF CHILDREN POSTED.

RATES ARE AS FOLLOWS
$94.00 INFANTS & 1YR. OLD $88.00 2 YR. OLD $83.00 3 AND 4 YR. OLD

$26.00 PART TIME (PER DAY) **DROP IN $6.00** (an hour 2an up) **Infants $8.00** an hour
$50.00 REG. FEE (NON-REFUDABLE)
**** AFTERSCHOOLERS $55.00** (during school year) **Ages 5 an up**
**** $83.00** (summertime & night time) **Ages 5 an up**

LIST ANY KNOWN ALLERGIES OR OTHER PHYSICAL PROBLEM, MENTAL HEALTH DISORDER, MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES.

_____
_____
_____

THE CENTER WILL PROVIDE TRANSPORTATION TO AND FROM SCHOOL ONLY.

I APPRECIATE YOU CONSIDERING THIS CENTER. I WILL TRY VERY HARD TO MAINTAIN AN EXCEPTIONAL CARE FACILITY. IF YOU HAVE PROBLEMS HERE, I ASK THAT YOU PLEASE LET ME KNOW. EVERYONE BENEFITS WHEN AN ERROR IS CORRECTED. THANKS FOR YOUR TIME. I LOOK FORWARD TO HAVING YOU WITH ME.

_____ _____
Parent's Signature **Date**

_____ _____
Director Signature **Date**

SAMPLE CHILDREN'S ENROLLMENT FORM

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)_____

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

Name_____Telephone Number_____

Name_____Telephone Number_____

Name_____Telephone Number_____

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 _____ agrees to provide child 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 _____ 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
_____.
(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)

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**

Bright from the Start: Georgia Department of Early Care and Learning

Child Adult Care Food Program

Income Eligibility Statement

ART I: Child(ren) or Adult enrolled to receive day care-

Name: (Last, First and Middle Initial)	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: A. Name (List everyone in household, including foster and non-foster children)	B. Gross income and how often it is received. Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
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 _____ [am/pm] to _____ [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 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 his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next 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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: X_____ Print Name _____ Date_____

Address:_____ City_____ State: GA Zip_____ Phone_____

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

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

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_____ Paid_____ Tier I_____ Tier II_____

Temporary: Free_____ Reduced_____ Time Period:_____ (expires after _____days)

Determining Official's Signature:_____ Date_____

Confirming Official's Signature:_____ Date_____

Follow Up Official's Signature:_____ Date_____

2/2011

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.