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

Address 1170 Cleveland Ave, East Point, GA 30344

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Day-Star Christian Academy
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 _____

DAY-STAR CHRISTIAN ACADEMY

Publicity Release Form

Throughout the school year Day-Star Christian Academy, Inc.® will conduct activities that may be publicized through social and local news media.

_____ **I grant permission** for my child to participate in any publicity activities sponsored by Day-Star Christian Academy, Inc.® Such as activities may include but are not limited to various print media and publications for Day-Star including newsletters, calendars, brochures, and websites; social media outlets including Facebook, Twitter, YouTube, Tic Toc, SnapChat, and Procare Connect; videotaping including promotional videos for Day-Star Christian Academy, Inc.®, videotaping for Georgia's Department of Early Care and Learning (DECAL), or local news media. I understand that this permission is effective as long as my child is enrolled in a program at Day-Star Christian Academy, Inc.® or until I give further notice.

_____ My child **may not** participate in any publicity activities sponsored by Day-Star Christian Academy, Inc.

Parent/Legal Guardian Signature Print Name

Witness Signature (Program Director) Print Name

Date

Parental Agreements with Child Care Facility

The Day-Star Christian Academy agrees to provide after school care for
(Name of Facility)
_____ on _____ 3:00 p.m. to 7:00 p.m.
(Name of Child) (Days of Week)
from August 2021 to May 2022 .
Month Month

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

Breakfast
Morning Snack
Lunch
◉ Afternoon Snack
Evening Snack
◉ PM Snack
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 Day-Star Christian Academy 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
Day-Star Christian Academy .
(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)

Family Handbook Acknowledgement

Please sign this acknowledgement, detach it from the handbook, and return it to the center prior to enrollment.

This handbook may be updated from time-to-time, and notice will be provided as updates are implemented.

Thank you for your acknowledging the policies and procedures we have established for the safety and welfare of all children in our care. We look forward to getting to know you and your family.

I have received the **Day-Star Christian Academy Family Handbook**, and I have reviewed the family handbook with a member of the Day-Star Christian Academy staff. It is my responsibility to understand and familiarize myself the Family Handbook and to ask center management for clarification of any policy, procedure or information contained in the Day-Star Christian Academy Family Handbook that I do not understand.

Recipient Signature _____ Date _____

Center Staff Signature _____ Date _____

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

Center: Day Star Christian Academy **CACFP Meal Benefit Income Eligibility Statement***

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

Name: (Last, First and Middle Initial) Date of Birth	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? $_____/_____

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. 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 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 _____-_____-_____ ☐ 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 3:00 [am/pm] to 7:00 [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 (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 ☐ 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**: _____

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

Child's Name (Last name, First name)

Birthdate

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

Date of Expiration

(Next required immunization or review of medical exemption due.)

(Fill in X)

Complete For K through 6th Grade

Child must be >= 4 years and have met all requirements for school attendance.

(Fill in X)

Complete For 7th through 10th Grade

Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

(Fill in X)

Complete For 11th Grade and higher

Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td											
Polio											
Hepatitis B											
Tdap											
MCV4											
HIB (Under Age 5)											
PCV (Under Age 5)											
Measles											
Mumps											
Rubella											
Hepatitis A (Born on/after 1/1/06)											
Varicella											
Recommended Vaccines (For Information Only)											
Rotavirus											
HPV											
Influenza											
Td (booster)											
Men-B											

Notes:

A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant**, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Certified by (Signature/Signature Stamp) **Date of Issue**

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

Georgia Department of Public Health
Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Parent/ Guardian Name:_____
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:_____

Evening phone number:_____

Cell phone number:_____

Child's Name:_____
first middle last

Date of Birth: _____/_____/_____ **Gender:** ❑**Male** ❑**Female**

Child's Home Address:

_____
street city state zip code county

VISION

❑ Unable to screen (explain why below)
❑ Uses corrective lenses
❑ Worn for testing

❑ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Optometrist
❑ "Prevent Blindness Georgia" employee
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

HEARING

❑ Unable to screen (explain why below)
❑ Uses hearing aid / assistive device

❑ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Audiologist
❑ Speech-Language Pathologist
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

DENTAL

❑ Unable to screen (explain why below)

❑ Normal appearance
❑ Needs further evaluation
❑ Emergency problem observed
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Dentist
❑ Local Health Department Registered Nurse
❑ Registered Dental Hygienist
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

NUTRITION

❑ Unable to screen (explain why below)

Height: _____ Weight: _____
BMI: _____ BMI%: _____

❑ 5th to 84th percentile - Appropriate for age
❑ < 5th percentile - Needs further evaluation
❑ ≥ 85th percentile - Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Registered Dietician
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

Who is required to file this Form 3300? The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

What is the purpose of Form 3300? Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

What screenings are required? Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

Who can conduct the screenings? Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietician or a school registered nurse. It is not necessary that the same person conduct all four screenings.

What does "BMI" and "BMI%" mean? "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietician for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

What should a parent do if the "needs further evaluation" box is checked? "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

What if a Form 3300 was previously filed for the child at another school? It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____
(Not to exceed two weeks without a physician's statement)

_____ _____
PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc…)

	DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	ADMINISTERED BY
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication