OMA'S LEARNING CENTER & DAYCARE

1345 W. Hill Ave
Valdosta, Ga. 31601
229-247-2313

ENROLLMENT FORM

Entrance Date: _____ Withdrawal Date:_____

Child's Name:_____
Birth Date: _____Age: _____ Female _____ Male _____
Address: _____
City _____ State _____ Zip code _____
Phone Number_____

Marital Status:

( ) Married ( ) Divorced ( ) Separated
( ) Single ( ) Widow

Person having custody of child: _____

Mother's Information

Mother's Name and address if different from child's

_____
Mother's Occupation _____
Social Security Number _____
Employer _____
Employer's address:_____
Business Number: _____ Phone Number: _____

Father's Information

Father's Name and address if different from child:

_____
Father's Occupation _____
Social Security Number _____
Employer _____
Business Number: _____Phone Number:_____

The child may be released to the following: (Note: Anyone not on the list will not be able to pick up the child, without written or oral statement from parent or guardian.)

Name	Address	Phone #	Relationship

Emergency contact when parents cannot be reached.

Name:_____ Phone: _____

OMA'S LEARNING CENTER & DAYCARE

VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____

Parent Name (Father): _____
Home Phone: _____ Work Number _____

Parent Name (Mother): _____
Home Phone: _____ Work Number: _____

In an emergency and parents cannot be reached:

Name: _____ Phone: _____

Child's Doctor: _____ Phone: _____

Medical Facility The Center Uses: _____

Address: _____

Child's Allergies: _____

Current Prescribed Medication: _____

Child's Special Medical Needs and Conditions: _____

_____

In the event of an emergency involving my child, and if OMA'S LEARNING CENTER cannot get in touch with me, I hereby authorize any needed emergency care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

CHILD'S NAME: _____

PARENT OR GUARDIAN: _____

WITNESSED BY: _____

DATE: _____

CHILD'S MEDICAL INFORMATION

Child's physician or clinic's name: _____

Telephone: _____

Does your child have any physical problems, mental health disorders, mental retardation or developmental disabilities, which would limit the child's participation in the center's program and activities?
( ) yes ( ) no
Specify: _____

Does child have allergies (insects, medications, foods, etc.)?
( ) yes ( ) no
Specify: _____

Any special procedures required in caring for child? ( )yes ( ) no
Specify: _____

Please list the last center your child attended:

_____
Reason(s)for leaving: _____

Name (PRINT) _____

Signature: _____

Date: _____

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EMERGENCY MEDICAL AUTHORIZATION

Should _____, _____ suffer an injury or
(Child's name) (Date of birth)
illness while in the care of **OMA'S LEARNING CENTER** and the facility is unable to contact me, the parent immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I, the parent shall assume responsibility for payment for services.

I, the parent agree to keep the facility informed of changes in telephone numbers, etc., and where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child/children.

Child's primary source of health care is: Physician/clinic name: _____

Telephone: _____

Any known Medical conditions (i.e. diabetic, asthmatic, drug allergies)

_____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

Telephone: _____

OMA'S LEARNING CENTER & DAYCARE AGREEMENT

1. Oma's Learning Center agrees to provide daycare for _____
Name child is called by

on _____ from _____a.m to _____p.m
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

2. Before any medication is dispensed to my child, I will provide a written authorization, which includes: dates, name of child, name of medication, prescription number, if any, dosage, dates and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

3. 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.

4. I acknowledge it is my responsibility to keep my child's shot 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.

5. The facility agrees to keep me informed of any incidents, including illness, injuries, adverse reactions to medications, etc., which include my child.

6. The Oma's Learning Center agrees to obtain written authorization from me before my child participates in routines transportation, field trips, and special activities

7. I have received a copy and agree to abide by the policies and procedures of OMA'S LEARNING CENTER & DAYCARE

Signature: _____ Date: _____
(Parent/ guardian)

Signature: _____ Date: _____

Oma's Learning Center

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TRANSPORTATION AGREEMENT

This is to certify that I give Oma's Learning Center permission to transport my child _____
(name of child)
from _____ in the morning at _____ am
(pick up location)
to _____ at _____ am on the following days.
(Delivery location)

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

My child will be transported from _____ in the afternoon
(pick up location)
at _____ pm, to _____ at _____ pm
(Delivery location)
on the following days.

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

_____ is authorized to receive my child. In the event the authorized person is not present to receive my child. The following procedure is to be followed.

_____

_____

_____

The _____ is approximately _____ miles from the center.
(Location)

In the event that my child is not to be transported as outlined above I will notify Oma's Learning Center.

Signature (Parent/Legal Guardian) _____

Date _____

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

Child Adult Care Food Program

Income Eligibility Statement

PART 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. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care .*

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/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ 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_____