TTLC 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

Work Phone #_____
Mother's Place of Employment_____

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_____

*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 preexisting 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.

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 _____. RATE: $ a WEEK
(Month) (Month)

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

Breakfast
Lunch
Afternoon 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)

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 formula used, if applicable?_____

Amount and time of formula/breast milk to be given?_____ 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 his/her 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		
TIME	AMOUNT	TYPE

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

_____

PARENT'S SIGNATURE: _____ Date: _____

Photo Release

This photo release is made effective on this _____day of ____, _____.
I _____, hereby grant and authorize **Tumbling Toddlers** the right to edit, alter, copy any and make use of all photos and or videos taken of me to be used for promotional materials without payment or consideration. This grant of use includes but is not limited to publishing on internet and e-mails, magazines pamphlets, advertisements, fliers, and in whatever manner the photographer finds useful for the prosperity and growth of **Tumbling Toddlers.**

_____ _____

Print Name Date

_____

Signature

Parents or Guardian's
Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, _____, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____

Parents or Guardian's Signatures Date

_____ _____

Parent or Guardian (Print Names) Date

_____ _____

Center Director's Signature Date

Tumbling Toddlers Learning Center

Child Information Disclosure Agreement

Childs Name:
Date:

Welcome to TUMBLING TODDLERS LEARNING CENTER! We are committed to providing a nurturing and supportive environment for all children. To ensure that we can meet your child's unique needs effectively, we kindly request your cooperation in disclosing any relevant information regarding your child's development.

Please provide details about the following:

1. Developmental delays or any disabilities- If your child has been identified or you suspect any developmental delays, please specify.

2.Autism Spectrum Disorders- If your child has been diagnosed with autism or is currently undergoing evaluation, please share this information. What level

3.Therapies- If your child is receiving any therapies (e.g., speech, occupational, behavioral etc.), please let us know the nature and frequency of these therapies.

4. Neurodevelopmental Disorders- If your child has been diagnosed with or you suspect ADHA, ADD or ODD (Oppositional Defiant Disorder) or are currently undergoing evaluation, please share this information.

Importance of Disclosure

Your transparency is vital for us to create an inclusive and supportive environment. If we later discover that information regarding your child's developmental or therapeutic needs was not disclosed, it may result in the termination of care at our facility. This policy is in place to ensure the safety and well-being of all children under our care.

Confidentiality Assurance

Please be assured that all information shared will be kept confidential and used solely for the purpose of enhancing your child's experience at our facility. Thank you for your

understanding and cooperation. If you have any questions or need assistance in completing this information, please do not hesitate to reach out to us.

Warm regards,

Mrs. Key & Mrs. Nique
Directors
Tumbling Toddlers Learning Center #2 & #3

Parent Signature

Date:

Director Signature

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) Birth Date:	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
	SNAP, TANF, or FDPIR Number,	☐	☐	☐	☐	☐
	or Client ID # (children only):	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
	SSI/Medicaid # (adults only):	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

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 ellgibility 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 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 (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: _____