Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
Phone: 404-696-3490
Rev. Charles Ramsey, Board Chairperson
Mr. Thomas Ford, Director

Student Name: _____

Enrollment Date: _____

Enrollment Process

_____Tour (Optional)

_____ Online Application (Trinity-elc.org)

_____Subsidized Certificates CAPS: _____ Boost: _____

_____Immunization Exp Date: _____ Refusal to Vaccinate: _____ Affidavit of Religious Objection: _____

_____ Name Tag and Cubby Tags Created

Enrollment Requirements

- ☐ Complete Online Registration
- ☐ Vehicle Emergency Medical Information
- ☐ Emergency Medical Authorization
- ☐ Authorization to Dispense External Preparations
- ☐ Parental Agreement
- ☐ Income Eligibility Form
- ☐ Intake Registry
- ☐ ProCare Tuition Payment Registry
- ☐ Trinity Parent Tuition Agreement
- ☐ *Safe Sleep Practices Policy (For Infants)
- ☐ *Infant Feeding Plan (For Infants)
- ☐ *Infant Affidavit (For Infants)

First Day Family Intake – Time In: _____ Time Out: _____

- ☐ Food Allergies or other Environmental Allergies _____Posted in the classroom_____
- ☐ Potty Trained: _____ In Training: _____
- ☐ Behaviors: Biting: _____ Hitting: _____ Kicking: _____ Temper Tantrums: _____
- ☐ Curriculum: Creative Curriculum _____
- ☐ Fingerprint Registration (Billing Bag and Student Picture) _____
- ☐ Special Diet: Vegetarian_____ Vegan_____ Milk Preferences_____

(All Children with special diets must have a doctor's note on file)

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Registration Requirements

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- € Certificate of Immunization
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Authorization to Dispense External Preparations

I give Trinity AME Early Learning Center, LLC permission to apply one or more of the following topical ointments/preparations/over the counter medications to _____ (Child's Name) 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
____ Insect Repellent
____ Non-Prescription Ointment (Such as A&D, Desitin, Vaseline)
____ Baby Powder

Other (Please Specify):
_____

Signature (Parent/Guardian): _____

Date: _____

* Trinity AME Early Learning Center, LLC will maintain a copy of this for the child's records.

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EMERGENCY MEDICAL AUTHORIZATION

Should (Child's Name) _____ suffer an injury or illness while in the care of (Facility Name) ____Trinity AME Early Learning Center_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 (Print Name): _____

Date: _____

Facility Administrator (Print Name): _____

Date: _____

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Parental Agreement with Trinity AME Early Learning Center, LLC

Trinity AME Early Learning Center agrees to provide care for _____ (Child's Name) on: **Monday, Tuesday, Wednesday, Thursday and Friday**. The care will be provided from _____ A.M. to _____ P.M.
My child will participate in the following meal plan:
Breakfast, Lunch, and an Afternoon Snack.

Before any medication is dispensed to my child, I will provide a written authorization which indicates dates, name of child, name of medication, prescription number, dosages, and the time the medication should be administered. Medicine must be in the original package with your child's name 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 contact, child's physician, child's health status, infant feeding plan 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.

Trinity AME Early Learning Center, LLC agrees to obtain written authorization from me before my child participates in routine transportation for field trips/special activities that are away from the facility. Trinity AME Early Learning Center, LLC agrees to obtain written authorization for my child to participate in water-related activities occurring in water that is more than two feet deep.

I authorize Trinity AME Early Learning Center, LLC 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 Trinity AME Early Learning Center, LLC.

I understand that the facility will advise me of my child's progress and issues pertaining 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 activities at Trinity AME Early Learning Center, LLC.

Signature: _____ **Date:** _____
(Parent/Guardian)
Signature: _____ **Date:** _____
(Facility Administrator)

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Vehicle Emergency Medical Information

Child's Name: _____ DOB: _____

Address: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____

Cell Phone: _____ Work Phone: _____

Person to notify in an emergency and parents cannot be reached:
Name: _____ Phone #: _____

Child's Doctor: _____ Phone #: _____

Medical Facility: _____

Address: _____

Child's Allergies: _____

Current Prescribed Medication: _____

_____

Child's Special Needs/Conditions: _____

_____

In the event of an emergency involving my child, and if **Trinity AME Early Learning Center, LLC** cannot get in touch with me, I hereby authorize any needed 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): _____

Witnessed By: _____ 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)	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:** _____