Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Rev. Conitras M. Houston, Board Chairperson
Mr. Thomas Ford, Executive Director

Registration Requirements

- ☐ Complete Online Registration
- ☐ Authorization to Dispense External Preparations
- ☐ Emergency Medical Authorization
- ☐ Parental Agreement
- ☐ Vehicle Emergency Medical Information
- ☐ Income Eligibility
- ☐ Intake Registry
- ☐ ProCare Tuition Payment Registry

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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) ______________________________________ 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: ___________________________

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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?
$________/__________

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 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:** ____________________________