INSPIRING SCHOLARS ACADEMY 2024/2025 STUDENT FILE CHECKLIST

Inspiring Scholars Academy LLC is licensed by Bright from the Start: the state of Georgia Licensing Agency for Daycares. As such, these forms are required as part of the guidelines of the state.

Each form must be completed in its entirety or the enrollment will not be accepted.

Child Name (s): ____________________

Date of Enrollment: ____________________

Start Date: ____________________

—-----------------------------------Office Only—-----------------------------

Place a check mark or N/A for each completed form on file.

___Registration Fee ___ Material Fee

___Completed enrollment forms

___Form 3231 (Immunization certificate for non- school age children)

___Birth Certificate

___Driver' s License

___Tuition Express

Registration $100 Pd Y N Material $40 Pd Y N

Staff Receiving: ____________________

2024-2025 Application
Inspiring Scholars Academy
13671 Veterans Memorial Hwy Winston, GA 30187

CHILD'S INFORMATION (Please print name as it appears on the birth certificate)		
CHILD'S LEGAL GUARDIAN: [ ] BOTH PARENTS [ ] MOTHER [ ] FATHER [] OTHER		
1.CHILD'S Name:		
CHILD'S D.0.B. (/ /): SEX: [ ] M [ ] F AGE:		
HOME ADDRESS:	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No		

CHILD'S INFORMATION (Please print name as it appears on the birth certificate)		
CHILD'S LEGAL GUARDIAN: [ ] BOTH PARENTS [ ] MOTHER [ ] FATHER [] OTHER		
1.CHILD'S Name:		
CHILD'S D.0.B. (/ /): SEX: [ ] M [ ] F AGE:		
HOME ADDRESS:	**COUNTY:**	
CITY:	**STATE:**	**ZIP:**
COPY OF IMMUNIZATION RECORD PROVIDED: Yes or No		

PARENT/GUARDIAN INFORMATION:		
MOTHER'S NAME:		
HOME ADDRESS: (If Different From Child)	COUNTY:	
CITY:	STATE:	ZIP:
PHONE:	Email Address:	
WORK PHONE:		
Copy of License Yes or No		

PARENT/GUARDIAN INFORMATION:		
Father’s Name:		
HOME ADDRESS: (If Different From Child)	COUNTY:	
CITY:	STATE:	ZIP:
PHONE:	Email Address:	
WORK PHONE:		
Copy of License Yes or No		

EMERGENCY CONTACT INFORMATION (Person to contact in the event that either parent/guardian cannot be contacted. Add additional contacts on back)
1. Contact NAME:
Contact Number :
EMERGENCY CONTACT INFORMATION (Person to contact in the event that either parent/guardian cannot be contacted. Add additional contacts on back)
2. Contact NAME:
Contact Number :
AUTHORIZED PICK-UP THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:
1. Contact NAME:
Contact Number:
2.Contact NAME:
Contact Number:

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER. To that end only Life Saving Medication will be given at our centers.

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS OR HEALTH CONCERNS: ____

_____ I UNDERSTAND A MEDICAL AUTHORIZATION FORM MUST BE COMPLETED GIVING INSPIRING SCHOLARS ACADEMY STAFF PERMISSION TO ISSUE MEDICATION TO MY CHILD. (Please initial)

CHILDS MEDICAL DOCTOR

If you do not have a doctor, please refer to:

Douglas County Health Center: 770-949-1970

Physicians Name ________________________

Physicians Number________________________

PARENTAL AGREEMENT INITIAL

____ NO CHILD WILL BE ALLOWED TO ENTER OR EXIT THE CENTER WITHOUT A PARENT OR A PERSONS AUTHORIZED BY THE PARENT.

____ YOU ARE RESPONSIBLE FOR KEEPING THE CENTER ADVISED OF SIGNIFICANT CHANGES AS THE CHANGES OCCUR IN THE INFORMATION YOU PROVIDED AT THE TIME OF ENROLLMENT. (PHONE NUMBERS, EMERGENCY CONTACTS, ETC....)

____ YOU HAVE RECEIVED A COPY OF THE CENTER'S PARENT HANDBOOK POLICY AND PROCEDURES BY EMAIL.

____ YOU WILL BE ADVISED OF YOUR CHILD’S PROGRESS.

I AUTHORIZE INSPIRING SCHOLARS TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD WHEN I'M NOT AVAILABLE AND I WILL NOT HOLD INSPIRING SCHOLARS RESPONSIBLE FOR ANY OF THE MEDICAL BILLS OR TRANSPORTATION FEES THAT OCCUR.

Signature (Parent/Guardian)________________________________Date_________

FEE AGREEMENT (INITIAL EACH LINE)

All custodial parents and/or legal guardians are required to sign a Fee Agreement prior to enrollment at **Inspiring Scholars Academy**. Parents are required to indicate to whom all billing information and correspondence is to be addressed. Please read and initial this agreement.

_____ (**Initial**) I understand Inspiring Scholars Academy will charge a **$5** service fee for check and money orders

_____ (**Initial)** I understand Inspiring Scholars Academy will charge a $36.00 fee for tuition checks returned by the bank. Returned tuition checks will not be re-deposited.

____ (**Initial)** I understand that Inspiring Scholars Academy does not accept cash

____ **(Initial)** I understand payments are due each Friday for the next week of care**.**

____ **(Initial)** I understand Inspiring Scholars Academy will charge a **$25.00** late fee if payment is not received by close of business day Monday. *Late fees will be charged weekly on all accounts with outstanding balances no matter the enrollment status.*

____**(Initial)** My child will not be able to attend until payment including late fees are not made. Termination of services for non-payment does not eliminate the mandatory two-week notification for your child(s) withdrawal.

_____**(Initial)** Official notification for withdrawal from Inspiring Scholars requires a minimum of two week notice in writing.

____ **(Initial)** I understand I will lose my sibling discount if my payment is late twice (2 times) within a school year.

____ (**Initial**) I understand tuition is not prorated and is due in full whether or not my child attends Inspiring Scholars Academy.

____ (**Initial**) I understand there is no credit/reimbursement given for scheduled school holidays, child illness, children with behavior issues, or for closings due to emergency situations, or inclement weather.

____ (**Initial**) I understand Inspiring Scholars Academy charges a **$1.00** per minute per child late fee after agreed pick up time.

____ **(Initial)** I understand my child has to be in school by 9:30 am or have a Doctor's excuse to sign in. ____ **(Initial)** I acknowledge that Inspiring Scholars charges $75.00 for annual school registration.

____**(Initial)** Delinquent accounts sent to collections will be charged a 30% collection fee in addition to the remaining balance.

____ **(Initial)** I understand my child can remain under our care for up to 10 hours per day.

____ **(Initial) Tuition Express** I understand and agree that any outstanding balance that is owed at the time of ending services will be deducted automatically from the information given on the Tuition Express form.

____ **(Initial) CAPS Clients Only** I understand that if I do not sign my child in/out daily, I will be charged full weekly payments for my child(s).

____ **(Initial) Daycare Only**. Children are allowed one week of vacation per calendar school year. Parents must provide a two-week notice in advance of vacation. If a notice is not provided, parents will be responsible for weekly payment.

Parent Name: ____

Parent Signature: ____

Parent Email: ____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for Inspiring Scholars Academy, which shall include, but not be limited to, the Georgia Department of Education, to record the participation and appearance of my child (1), ___________________, child (2)_____________________, child(3)_______________by photograph and/or videotape in connection with daily activities for the purposes of news releases, reporting, and assessing the progress of children and the program. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for Inspiring Scholars Academy and/or on Inspiring Scholars Academy website.

The undersigned hereby jointly and severally releases, acquits, forgives, Inspiring Scholars Academy, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child. This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by the law.

Signature: ____ **Date**: ________________

Food Allergy Action Plan

Student's Name:____________________________________ D.O.B:________________________

ALLERGY TO:____

Asthmatic? Yes*______ No______ * Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: **Give Checked Medication**:**
(To be determined by physician authorizing treatment)

- If a food allergen has been ingested, but ***no symptoms****:* ☐ Epinephrine ☐ Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth ☐ Epinephrine ☐ Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities ☐ Epinephrine ☐ Antihistamine
- Gut Nausea, abdominal cramps, vomiting, diarrhea ☐ Epinephrine ☐ Antihistamine
- Throat‡ Tightening of throat, hoarseness, hacking cough ☐ Epinephrine ☐ Antihistamine
- Lung ‡ Shortness of breath, repetitive coughing, wheezing ☐ Epinephrine ☐ Antihistamine
- Heart ‡ Thready pulse, low blood pressure, fainting, pale, blueness ☐ Epinephrine ☐ Antihistamine
- Other ‡ ____ ☐ Epinephrine ☐ Antihistamine
- If reaction is progressing (several of the above area affected), give: ☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. ‡ Potentially life threatening.

DOSAGE:
Epinephrine: inject intramuscularly (circle one) EpiPen™ EpiPen™Jr. Twinject™0.3 mg Twinject™0.15mg

Antihistamine: give ____
medication/dose/route

Other: give____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad:__________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ________________________________ at ____

3. Emergency contacts:
   Name/Relationship Phone Number(s)

   A. ____________________________________ 1.) ____________________ 2.) ____________________

   B. ____________________________________ 1.) ____________________ 2.) ____________________

   C. ____________________________________ 1.) ____________________ 2.) ____________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _______________________________________ Date _______________

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of the parent.

I give ____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____Bandaids
_____ Bactine or similar first aid spray
______Neosporin or similar ointment
_____Bactine or similar first aid spray
_____ Sunscreen
_____ Non-Prescription ointment (such as A & D: Desitin, Vaseline)
____ Other (please specify):

Signature: ____ **Date**: _____________

Inspiring Scholars Academy

OBSERVE HOLIDAYS 2024-2025

CLOSED

June 19th - Juneteenth
July 4th - Independence Day
September 2- Labor Day
November 28-29th - Thanksgiving
December 24-25th - Christmas Eve/Day
January 1st - New Years
April 18th - Good Friday
May 26th - Memorial Day

(Parent Copy)

Daycare Hours 6:00am-6:00pm (max 10 hrs.)

9:30am is the latest a child can be dropped off without a Doctor, Dentist, or WIC letter. **Breakfast ends @ 8:30am**

Late Pick-up: Late pick up will result in a late fee of **1st Time**= $1 per minute, **2nd Time**= $3 per minute **3rd Tim**e= $5 per minute per child. Late fee must be paid at the time of pick-up.

Tuition: Payment is due Friday or Monday before your child is dropped off.

Check fee: There is a $5 service fee for checks and money orders. Cash not accepted

Returned check fee: $36

Late Fee: $25 late fee if payment is not received by 7pm Mondays'. Late fees will be charged weekly on all accounts with outstanding balances enrolled/unenrolled status.

Non Payment: Services will be suspended until full payment is made including late fees. Termination of services for non-payment does not eliminate the mandatory two week notification of your child(s) withdrawal.

The sibling discount benefit will be discontinued if there are 2 consecutive late payments of tuition.

A written **2-week notice** is required to terminate service offered by Inspiring Scholars.

Refund Policy: No refunds will be given.

Sign-In and Sign-Out: Only adults listed on the "authorized pick-up list" section of the Registration Form with photo ID will be permitted to pick-up your student. Please be sure to include anyone that you may want /need to pick-up your student on the registration form.

Personal Items: Students should not bring toys, electronic devices or unsecured personal items. Inspiring Scholars will not be held liable for any lost and/or damaged items.

Medication: We have a NO MEDICATION policy. Exceptions may be made for life sustaining medication. If accepted, a consent form must be filled out and put on file.

Outside food is not allowed