

ABC CHILD CARE CENTER, INC.
2009-2010 Pre-Kindergarten Program Application

Site Preferred

- 1106 East 48th Street 912-355-1442
- 8805 Whitebluff Road 912-927-4313

Office Use Only

- Proof of GA Residency
- Birth Certificate
- Social Security Card
- GA Immunization Form 3231
- G A EED Form 3300
- CACFP Application
Date of Completed Application _____

Child's Name: _____

(Last) (First) (Middle) (Name to be Used)

DOB: ____/____/____ Child's Social Security Number: ____-____-____ Race: _ White _ Black _ Other

Child's Address: _____ Apt#: _____ City: _____ Zip: _____

Child lives with: _____ Relationship: _____ Home Phone#: _____

Mother's Name: _____ Social Security #: _____ - _____ - _____

Employer: _____ Department: _____ Work Hours _____ to _____

Work Phone #: _____ Extension (_____) Cell#: _____ Pager #: _____

Email Address: _____

Father's Name: _____ Social Security #: _____ - _____ - _____

Employer: _____ Department: _____ Work Hours _____ to _____

Work Phone #: _____ Extension (_____) Cell#: _____ Pager #: _____

Email Address: _____

Emergency Contacts other than Parents (Persons listed below have authority to pick up my child):

Name: _____ Name: _____

Address: _____ Address: _____

Home#: _____ Work#: _____ Home#: _____ Work#: _____

Relationship to child: _____ Relationship to child: _____

Name: _____

Name: _____

Address: _____

Address: _____

Home#: _____ Work#: _____

Home#: _____ Work#: _____

Relationship to child: _____

Relationship to child: _____

Name	Age	Grade	Name of School Attending
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Acceptance into the program depends on available openings.

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Please describe any disabilities, specific problems, or special needs of the child _____

Child's Medical History: _____

List all known Allergies: _____

In the event reasonable attempts to reach me or other emergency contacts listed for my child are unsuccessful, I hereby give my consent for (1) the Administration of any treatment deemed necessary by Dr. _____ whose telephone number is _____ or Dentist _____ whose telephone number is _____ or by any other practitioner in the event they are not available; and/or (2) the transfer of my child to my preferred hospital _____ or any other accessible health care facility. I accept full responsibility for the payments of all charges made for medical services rendered. I absolve center officials of any liability who, in good faith, comply with this request.

Check each of the following which the family/child receives:

1. Child's Medicaid# _____
2. Food Stamp# _____
3. TANF# _____
4. SSI _____
5. Peach Care for Kids _____

I do not meet the criteria for assistance listed above. ____

Please initial the following statements - If my child is accepted, I agree to:

- Have my child in school every day, unless ill.
- Have my child arrive on time - 8:30 a.m.
- Pick up my child on time each day - 3:00 p.m.
- Attend parent meetings/workshops once a month.
- Attend two parent/teacher conferences per school year
- Provide original documentation for SSN, EED, Birth Certificate, Immunization Form 3231 and Georgia residency at time of registration.
- Provide documentation for items #1-4 checked above.

Signature of Mother: _____

Date: _____

Signature of Father: _____

Date: _____

Signature of Director: _____

Date: _____

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