For Office Use Only

Date Received:	
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Early Eagle Academy

Application Form for GCMS

Student Information

Child's First Name: _____ Child's Middle Name: _____ Child's Last Name: _____

Child's Age: _____ Child's Birthday: _____

Nickname: _____

Application Completion Date: _____

Address: _____

_____

Parent Information

Mother's Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail Address: _____

Father's Name: _____

Home Phone: _____

Work Phone:_____

Cell Phone:_____

E-mail Address: _____

Parents are:
Married _____
Divorced _____
Separated _____
Widowed _____
Single _____

Mother's Employer (include name and address, telephone number and extension):

_____

_____

Telephone: _____

Hours of employment are from _____ a.m. to _____p.m.

Father's Employer: (include name and address, telephone number and extension):

_____

_____

Telephone: _____

Hours of employment are from _____ a.m. to _____p.m.

School Information

Beginning date needing care_____

We offer full time and part time childcare services. Our full-time program is Monday-Friday from 7:00 a.m. to 5:00 p.m. Our part-time program is offered as a wrap-around program for our Graves County Preschool students. We also offer drop-in/emergency care services as space is available.

Please indicate the program in which you are interested.

____ Full Time Program (7:00 a.m.-5:00 p.m.)
____ Part Time Program (1/2 day for Preschool Wrap-Around)
____ Two Day Program Days:_____
____ Three Day Program Days:_____
____ Drop-In/Emergency Services

Times you plan to drop off your child_____

Times you plan to pick up your child_____

(Our main instructional lessons are from 8:30 a.m.-11:30 a.m. each day. We ask that you do not pick up or drop off your child during this time.)

Emergency Contacts/Authorized Transportation Individuals
(Please list all people that are authorized to be contacted in case of emergency and that can transport your child to and from school.)

Name:	Phone Number(s):

Doctor's name_____

Doctor's phone number_____

Are your child's immunizations up to date? _____
(Please attach a copy of immunizations. This should include the signature of the nurse or doctor who administered medications.)

Does your child have any known allergies?

_____

_____

Does your child have any medical conditions in which we should be made aware?

_____

_____

Does your child have any hearing or visual problems? If so, please list:

_____

_____

Has your child had the following common childhood illnesses? (*please circle*)

Does your child have any problems with any of these?
Constipation
Convulsions
Diarrhea
Fainting Spells
Frequent Colds
Frequent Ear Infections
Frequent Sore Throats
Lice

Has your child had any of these diseases?
Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Hepatitis
Impetigo
Measles

Ringworm
Skin Rash
Soiling
Stomach Upsets
Urinary Problem
Worms

Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

Any specific concerns?_____

_____

Parent Signature: _____ Date: _____

Authorization for Emergency Medical Care - Permission to Treat

Child's Name		Date	
Child's Physician's Name		Phone	
Address			
Child's Dentist		Phone	
Address			

Authorized Adults

Please indicate the names and contact information where you and other authorized persons can be reached.

Father's Name	Hm #	Wk #	Cell #	Other
Mother's Name	Hm #	Wk #	Cell #	Other
Other Authorized Person	Hm #	Wk #	Cell #	Other
Address				

First Aid

In the event of an emergency, I authorize the staff of Early Eagle Academy to provide any first aid care deemed necessary for my child.

Parent's Signature/Date

Emergency Care

In the event of an emergency in which I cannot be reached, the physician listed above or the local hospital are authorized to provide any emergency care deemed necessary for my child.

Parent's Signature/Date

Health Record Transfer

In the event of an emergency, I authorized the transfer of my child's health records to the appropriate medical team.

Parent's Signature/Date

Hospital of Choice

I would like my child to be transported to the following hospital via ambulance if needed.

Hospital Name

Insurance Information

Insurance Company

ID Number	Subscriber Name

Additional Instructions: Please list any allergies your child may have.

CHILD ENROLLMENT FORM/INCOME APPLICATION

Participant Information: (To be completed by Parent/Guardian)

If a child is a SNAP/K-TAP recipient or a Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 2.)

Participant's Last Name	Participant's First Name	Date of Birth *If under 12 months, please complete Infant Addendum*	Meals Normally Eaten (Circle all that apply)	Head start	Foster	SNAP or K-TAP # List Entire SNAP or K-TAP CASE NUMBER Below
			B AM L PM S LN	☐	☐	
			B AM L PM S LN	☐	☐	
			B AM L PM S LN	☐	☐	
			B AM L PM S LN	☐	☐	

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

If child receives Head start services, please proceed to complete Section 2. Household Income is not required.

1. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above Last, First	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other MONTHLY Income Including Money Received from Kinship/Foster Child
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$

2. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____ _____

Signature of Adult Household Member **Home/Cell Phone Number**

X_____ ☐ No Social Security Number X_____

Last four digits Social Security Number* **Date**

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Application approved for:

- ☐ Free Meals
- ☐ Reduced Meals
- ☐ Paid Meals
- ☐ SNAP/KTAP
- ☐ Foster
- ☐ Headstart
- ☐ Income Household

Total Household Monthly Income_____

Household Size_____

_____

Signature of Determining Official

_____

Date

**7 CFR 226.15 (e)(2)*

(Revised February 2018)

"The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The last four digits of the Social Security Number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program."