**Dougherty County Pre-K**
**1520 Cordell Avenue**
**Albany, Georgia 31705**
**Dr. Linda Gail Solomon-Pre-K Director**

**DCSS PRE-K OFFICE: (229)-431-1290 FAX: (229) 431-3423**

## REGISTRATION CHECK OFF LIST
## ALL INFORMATION IS NEEDED AT THE TIME OF REGISTRATION
**(KEEP THIS SHEET WITH YOUR APPLICATION)**

_____ **Current Immunization Record (DHR FORM 3231)**

_____ **Proof of Residence – We must have a utility bill with the name and address of the person responsible for the bill. If you live with someone and the bill is in their name we must have a NOTARIZED LETTER OF RESIDENCY FORM AND THE UTILITY BILL. (Attached to application)**

_____ **Parent Information Sheet - If you have child(ren) in school please make sure you put their name, grade and school on the bottom of the sheet)**

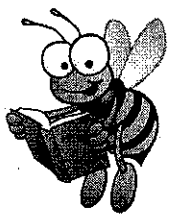
_____ **Public Assistance (If you check you receive assistance you must provide a copy of the information at the time of registration) Proof of public assistance: Copy of TANF, Food Stamps with SNAP/AU number, Peach Care, Medicaid, SSI**

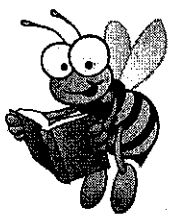
_____**Social Security Card - (You may use a print out from the Social Security Office if it is current and you are waiting for the card to be mailed to you.)**

_____**Certified Birth Certificate (with the seal)**

_____ **Vision, Hearing, Dental & Nutrition Screening (DHR FORM 3300) - A copy of your appointment card or statement with scheduled appointment is required at the time of registration. Please make sure that the doctor's name, address and contact information is filled out on the form.**

**Thank you for selecting the DCSS Pre-K Program a place for your child to learn, grow and exceed beyond all expectations.**





## For More Information Contact:

## MS. MONIQUE GORDON – OFFICE MANAGER @ 229-431-1290

# 2018-2019 DCSS Sylvandale Academy Prekindergarten Program Application

**Date of Application:** _____ **Date Application was Received:** _____

**Child's Name** _____
(Last) (First) (Middle)

**Present Address** _____
(Zip)

**Home Telephone #**_____ **Mother Cell #** _____ **Father #** _____

**E-Mail Address:** _____

**Child's Birth Information: Date** _____ **Child's Social Security #** _____

**Race and Gender of Child:**
**Black Male** _____ **Black Female** _____
**White Male** _____ **White Female** _____
**Hawaiian Male** _____ **Hawaiian Female** _____
**Asian Male**_____ **Asian Female**_____
**American Indian Male**_____ **American Indian Female**_____

**Who does the child live with? (√) (Check all that applies):**

**Mother** _____ **Father** _____ **Step-Parent** _____ **Foster Parent** _____ **Other** _____
(Name and Relationship)

**Mother's Name** _____
(Last) (First) (Work Phone #)

**Father's Name** _____
(Last) (First) (Work Phone #)

**Address for bus pick-up** _____

**Address for bus drop-off** _____

**Requests Extended Day Services** _____

**Emergency contacts other than guardians (Must have a phone number)**

(1) _____
(Name) (Address) (Phone Number)

(2) _____
(Name) (Address) (Phone Number)

(3) _____
(Name). (Address) (Phone Number)

**Check if you receive the following: SSI** _____ **Medicaid** _____ **TANF** _____**Food Stamps** _____**SSI**_____
**Peach Care /State Medicaid** _____
_____**CHECK HERE IF YOU DO NOT RECEIVE ANY TYPE OF PUBLC ASSISTANCE**

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**For Office Use Only: Assigned Teacher** _____ **Enrollment Date** _____

**Withdrawal Date:** _____ **Student Replaced With:** _____

**Category (1 or 2)** _____ **Verified Eligibility** _____ **BC** _____ **SS Card** _____ **Immunization (Exp)** _____

**EED** _____ **Roster Form** _____ **Proof of Residence** _____

**Zoned School** _____ **Zoned School #** _____

**Revision Date 01/09/2018**

BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

# Pre-K Registration Form

2018-2019 School Year

**PROVIDER LEGAL NAME:** Dougherty County Pre-K Program (This section to be completed by the provider)

**SCHOOL/SITE NAME:** Sylvandale

| CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.) | | | |
|---|---|---|---|
| CHILD'S LAST NAME: | | | |
| CHILD'S FIRST NAME: | | | |
| CHILD'S MIDDLE NAME: | NAME SUFFIX: (i.e. Jr, Sr, II,III) | | |
| CHILD'S SOCIAL SECURITY#: | D.O.B. (MM/DD/BY): | SEX: [ ]M [ ]F | |
| HOME ADDRESS (*Do not enter PO Box Info*): | | COUNTY: | |
| CITY: | STATE: GA | ZIP: | HOME PHONE: ( ) |

**If the Student is transferring from another Pre-K, please provide the following:**
Previous School Name: _____ Last Date in Attendance: _____

| PARENT/GUARDIAN INFORMATION | | | |
|---|---|---|---|
| Parent/Guardian #1 - LAST NAME: | FIRST: | | MIDDLE INITIAL: |
| Home Address (*If different from child*): | | | |
| City: | State: | Zip: | |
| Home Phone: ( ) | | Cell Phone: ( ) | |
| Email Address: | | | |
| Place of Employment: | | Work Phone: ( ) | |
| Address: | | | |
| City: | State: | Zip: | |
| Parent/Guardian #2 - LAST NAME: | FIRST: | | MIDDLE INITIAL: |
| Home Address (*If different from child*): | | | |
| City: | State: | Zip: | |
| Home Phone: ( ) | | Cell Phone: ( ) | |
| Email Address: | | | |
| Place of Employment: | | Work Phone: ( ) | |
| Address: | | | |
| City: | State: | Zip: | |

| EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted) | | | | |
|---|---|---|---|---|
| NAME | RELATIONSHIP | CELL PHONE | ALTERNATE PHONE | EMAIL |
| 1. | | | | |
| 2. | | | | |

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

**Signature Parent/Guardian:** _____ **DATE:** _____

**CHILD MAINTENANCE**

CHILD'S LIVING ARRANGEMENTS: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

CHILD'S LEGAL GUARDIAN: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

**THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:**

| NAME | ADDRESS | RELATIONSHIP | CELL PHONE |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE):** _____

DATE OF LAST FULL HEALTH SCREENING: _____ PHONE: ( )

**MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):**

**THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:**

**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:**

## GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

**SIGNATURE (Parent/Guardian):** _____

**DATE:** _____

## PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, 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 law.

**PRE-K PROVIDER NAME/ADDRESS:** _____

**SIGNATURE (Parent/Guardian):** _____

**DATE:** _____

# DCSS PRE-K NOTORIZED RESIDENCY FORM

**Dougherty County Pre-Kindergarten Program – 1520 Cordell Avenue – Albany, Georgia**
**Dr. Linda Gail Solomon – Pre-K Director**
**Office - 229-431-1290 Fax – 229-431-3423**

**Date:**_____

**Reference: Verification of Residency Status**

**This is to verify that I** _____**, parent of**

_____**reside in the home of/with/or in the name of/**

_____.

**I/We understand that if this information is false, we are in violation of Georgia Code 16-10-20 which has reference to "false statements and writings, concealment of facts, and fraudulent documents in matters within the jurisdiction of state or political subdivisions.**

**I/We also understand that if any of this information is false, I/We are in violation of the federal desegregation court order. A person convicted of this offense will be punished by a fine of not more than $1,000 or by imprisonment for not less than one no more than five years, or both.**

**The utility bill is not in my name but it is in the name of** _____
**who does/or does not actually live in the house with us.**

_____

**Notary**

_____

**My Commission Expires**

**Signature**_____ **Date:**_____

**Signature**_____ **Date:**_____

# Georgia Department of Public Health
# Form 3300

## Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

*PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM*

**Parent/ Guardian Name:** _____
first middle last

**Parent/ Guardian Contact Information:**

Daytime phone number: _____

Evening phone number: _____

Cell phone number: _____

**Child's Name:** _____
first middle last

**Date of Birth:** ____/____/____ **Gender:** ❑Male ❑Female

**Child's Home Address:**

_____
street city state zip code county

### VISION

- ❑ Unable to screen (explain why below)
- ❑ Uses corrective lenses
- ❑ Worn for testing

- ❑ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
- ❑ Needs further evaluation
- ❑ Under professional care (explain below)

**Screening completed by:**
- ❑ Physician
- ❑ Local Health Department
- ❑ Optometrist
- ❑ "Prevent Blindness Georgia" employee
- ❑ School Registered Nurse

_____
**Screener's Signature** **Date**

*I certify that this child has received the above screening.*

**Contact Information:**

### HEARING

- ❑ Unable to screen (explain why below)
- ❑ Uses hearing aid / assistive device

- ❑ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
- ❑ Needs further evaluation
- ❑ Under professional care (explain below)

**Screening completed by:**
- ❑ Physician
- ❑ Local Health Department
- ❑ Audiologist
- ❑ Speech-Language Pathologist
- ❑ School Registered Nurse

_____
**Screener's Signature** **Date**

*I certify that this child has received the above screening.*

**Contact Information:**

### DENTAL

- ❑ Unable to screen (explain why below)

- ❑ Normal appearance
- ❑ Needs further evaluation
- ❑ Emergency problem observed
- ❑ Under professional care (explain below)

**Screening completed by:**
- ❑ Physician
- ❑ Dentist
- ❑ Local Health Department Registered Nurse
- ❑ Registered Dental Hygienist
- ❑ School Registered Nurse

_____
**Screener's Signature** **Date**

*I certify that this child has received the above screening.*

**Contact Information:**

### NUTRITION

- ❑ Unable to screen (explain why below)

Height: _____ Weight: _____

BMI: _____ BMI%: _____

- ❑ 5th to 84th percentile - Appropriate for age
- ❑ < 5th percentile - Needs further evaluation
- ❑ ≥ 85th percentile - Needs further evaluation
- ❑ Under professional care (explain below)

**Screening completed by:**
- ❑ Physician
- ❑ Local Health Department
- ❑ Registered Dietician
- ❑ School Registered Nurse

_____
**Screener's Signature** **Date**

*I certify that this child has received the above screening.*

**Contact Information:**

**FOR SCHOOL SYSTEM ONLY** Follow up for further evaluation

| | 1st attempt | 2nd attempt | Actions reported (if any) |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Dental | | | |
| Nutrition | | | |

Student support services initiated on:

**Screeners' Comments:**

# STUDENT TRANSPORTATION REQUEST FORM

*Transportation Department . (229) 431-1265 . Fax (229 ) 431-3419*

**SY:** 2018-2019 **Date:** _____

| STUDENT INFORMATION | | | |
|---|---|---|---|
| New School Year: ✓ | New Rider: ✓ | Change of Information: | |
| Student Name: | | DOB: | Sex: |
| Student ID: | Grade: Pre-K | School: | |
| Home Address: | | | |
| Home Phone: | Work Phone: | Cell Phone | |

***Student Resides With:***

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |

Are you requesting alternate pickup and delivery locations other than home address? Yes ☐ No ☐

## HOME TO SCHOOL TRANSPORTATION

Will your child ride the bus to school from home? Yes ☐ No ☐

If no, give name of person or Child Care Facility at alternate location: _____

Address of alternate location: _____

Phone number at alternate location: _____

## SCHOOL TO HOME TRANSPORTATION

Will your child ride the bus from school to home? Yes ☐ No ☐

If no, give name of person or Child Care Facility at alternate location: _____

Address of alternate location: _____

Phone number at alternate location: _____

Parent/Guardian Signature: _____ Date: _____

***School Use Only***

**Please Circle One:** (School Type) ***Regular Ed.*** ***Gifted*** ***Pre-K*** ***Exceptional Students*** ***Oak Tree***

**Please Circle One:** (Bus Type) ***Reg. Ed.*** ***ESP/Reg. Ed.*** ***ESP*** ***ESP/3-4yr old*** ***Lift Bus*** ***Oak Tree*** ***Pre-K***

School Official: _____ Date: _____

*Signature*

***TRANSPORTATION DEPARTMENT USE ONLY***

The above request has been: Approved ☐ Not Approved ☐

Transportation Official: _____ _____

*Signature* *Date*