BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Scholarship/Registration School Year

PROVIDER LEGAL NAME: UNFOLDING FAITH D.B.A CAMP EXPLOSION (This section to be completed by the provider)

SCHOOL SYSTEM/SCHOOL:

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/Parent receives SNAP, PEACH CARE, MEDICAID, MEDICARE please provide the following:
CLIENT ID #:_____PROGRAM:_____

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 SOCIAL SECURITY #	D.O.B (MM/DD/BY)	
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 scholarship. If my child is allotted a scholarship, 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 accurate information and documentation scholarship processing will be delayed or denied. I have attached a copy of accurate information and 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: IEP OR 504 PLAN ATTACH DOCUMENTATION
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: ADHD, ADD, ATTACH DOCUMENTATION