KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Baker, Brixton Trevor	**State Student ID:** 2609495
Date of Birth: 05/10/22	**Classroom:** Room 7
Parent / Guardian: Quincy (Quinay) Baker	**Contact Phone:** 404-510-9426

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Baker_Brixton_Trevor.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_34c9a4.pdf	13	✓ ON FILE
3	**Certified Birth Certificate**	test_birth_cert.pdf	1	✓ VERIFIED
4	**Parent / Guardian Photo ID**	20260918_140734.jpg	1	✓ VERIFIED
5	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	Brixton Baker 3300 dental form.pdf	2	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609495
Student Name: Baker, Brixton Trevor	**Date of Birth:** 05/10/22
Parent(s)/Guardian: Quincy (Quinay) Baker	**Phone:** 404-510-9426

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ RECEIVED	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ RECEIVED	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609495

Scan the QR code or click the link above. Use child's Date of Birth (**05/10/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Baker, Brixton Trevor** Parent Signature: _____ Date: _____

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-2027 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDAZZLE - SUMMIT

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME:	BAKER		
CHILD'S FIRST NAME:	BRIXTON		
CHILD'S MIDDLE NAME:	TRENOIR	NAME SUFFIX:	(i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#:	712 89 2040	D.O.B. (MM/DD/BY): 05/10/22	SEX: [✓]M [ ]F
HOME ADDRESS (*Do not enter PO Box Info*):	1079 REGENT ST SW	COUNTY:	FULTON
CITY: ATLANTA	STATE: GA	ZIP: 30310	HOME PHONE: (470) 312-8733

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:	BAKER	FIRST: QUINAY	MIDDLE INITIAL: A
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: (470) 312-8733	
Email Address:	QUINAY.ALEESE@GMAIL.COM		
Place of Employment:	SIGNIA HILTON	Work Phone: (404) 223-4414	
Address:	159 NORTHSIDE DR NW		
City: ATLANTA	State: GA	Zip: 30310	
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. WAYNE BAKER	GRANDFATHER	718-810-4330	917 371 8194	WTD3343@yahoo.com
2. Kim BAKER	GRANDMOTHER	516-507-0979	516 546 9501	KABAKER811@GMAIL.COM

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:** 1/22/26

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. WAYNE BAKER	2324 CHURCH ST. LOVEJOY, GA	GRANDFATHER	718 810 4430
2.			
3.			
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): MOREHOUSE HEALTHCARE

DATE OF LAST FULL HEALTH SCREENING: _____ PHONE: (404) 752 - 1000

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

~~PEANUT ALLERGY - EPIPEN~~

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:

PEANUT ALLERGY - EPIPEN MILK INTOLERANCE

CETIRIZINE - ALLERGIES

ALBUTEROL INHALER - AS NEEDED

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: 2/13/26

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, BRIXTON BAKER, 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: 2/13/26

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1. KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 8/3/26 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

BRIXTON BAKER

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Lunch Afternoon Snack Dinner (school age only)

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: _____

Date: 2/13/26

Facility Administrator Signature: _____

Date: 8/3/24

Georgia Dept of Early Care and Learning
RIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2/13/26

CHILD INFORMATION:

Legal First Name: BRIXTON
Name Suffix (Jr,II,III):
Legal Middle Name: TREVOR
Name Child is Called:
Legal Last Name: BAKER
Child's Social Security #: 712-89-2040
DOB (M/D/Y): 05/10/2022
Gender: M ☑ F ☐
Choose Not to Provide SSN ☐
Date enrolled in Pre-K (M/D/Y): / /

PARENT/GUARDIAN INFORMATION:

Last Name: BAKER
First Name: QUINAY
Relationship: Mother ☑ Father ☐ Grandparent ☐ Guardian ☐ Other ☐
Email Address: QUINAY.ALEESE@GMAIL.COM
Zip Code: 31810

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English)? SPANISH

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

Parent/Guardian Signature — **Date** 2/13/26

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 2/13/20

Administrative Signature: _____ **Date:** 8/3/24

Teacher Signature: _____ **Date:** _____

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

BAKER, BRIXTON TREVOR
Child's Name (Last name, First name)

05 | 10 | 2022
Birthdate

BAKER, QUINAY ALICIA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

☐ (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

☐ (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

☐ (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	09 12 22	11 14 22	02 14 23	09 11 23			4				
Polio	09 12 22	11 14 22	02 14 23	09 11 23			4				
Hepatitis B	05 10 22	09 12 22	11 14 22				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	09 12 22	11 14 22	02 14 23	09 11 23			4				
PCV (Under Age 5)	09 12 22	11 14 22	09 11 23				3				
Measles	06 05 23						1				
Mumps	06 05 23						1				
Rubella	06 05 23						1				
Hepatitis A (Born on/after 1/1/06)	09 11 23	05 16 24					2				
Varicella	06 05 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus	09 12 22	11 14 22					2				
HPV							0				
Influenza							0				
Td (booster)							0				
Men-B							0				

Notes:

Licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Morehouse Healthcare
Comprehensive Family Healthcare Center
455 [illegible] Street, 2nd Floor
Atlanta, Georgia 30310



Production Region
17.0.0

- **Immunizations**
- **Reports**
- **Organizations**
- **General**
- **Admin Support**
- **Patients**

Client Information **VFC Eligible: Yes**

Client Name (First - MI - Last)	Birth Date	Gender	Mother's Maiden	Tracking Schedule	Chart #
BRIXTON TREVOR BAKER	05/10/2022	M	BAKER	CDC/ACIP	100821794

Address 960 COLEMAN ST SW, ATLANTA, GA 30310 (470) 342-3355

Comments

Current GRITS ID: 24059031 ... use this ID when contacting the help desk

Lead Screening: This child is served by Medicaid and must have a blood lead screening if under five years old. Please ask the parent or guardian with the child about possible lead exposure hazards. A follow up test is recommended within three months of confirmed lead poisoning test result of 10.00 µ/dl, or above.

Add Lead Action

History

Add Immunization | Edit Client | Reports | Print | Print Confidential

Vaccine Group	Date Administered	Series	Trade Name (Vaccine)	Dose	Owned?	Reaction	Hist?	Edit
DTP/aP	09/12/2022	1 of 5	Pentacel®	Full				
	11/14/2022	2 of 5	Pentacel®	Full				
	02/14/2023	3 of 5	Pentacel®	Full				
	09/11/2023	4 of 5	Pentacel®	Full				
HepA	09/11/2023	1 of 2	Havrix Peds 2 dose®	Full				
	05/16/2024	2 of 2	Havrix Peds 2 dose®	Full				
HepB	05/10/2022	1 of 3			No		Yes	
	09/12/2022	2 of 3		Full				
	11/14/2022	3 of 3	Engerix-B Peds®	Full				
Hib	09/12/2022	1 of 4	Pentacel®	Full				
	11/14/2022	2 of 4	Pentacel®	Full				
	02/14/2023	3 of 4	Pentacel®	Full				
	09/11/2023	4 of 4	Pentacel®	Full				
Measles	06/05/2023	1 of 2	MMR II®	Full				
Mumps	06/05/2023	1 of 2	MMR II®	Full				
PCV	09/12/2022	1 of 3	Prevnar 13®	Full				
	11/14/2022	2 of 3	Prevnar 13®	Full				
	09/11/2023	3 of 3	Prevnar 13®	Full				
Polio	09/12/2022	1 of 5	Pentacel®	Full				
	11/14/2022	2 of 5	Pentacel®	Full				
	02/14/2023	3 of 5	Pentacel®	Full				
	09/11/2023	4 of 5	Pentacel®	Full				
Rotavirus	09/12/2022	1 of 3	Rotarix®	Full				
	11/14/2022	2 of 3	RotaTeq®	Full				
Rubella	06/05/2023	1 of 2	MMR II®	Full				
Varicella	06/05/2023	1 of 2	Varivax®	Full				

Current Age: 3 years, 8 months, 20 days

Vaccines Recommended by Selected Tracking Schedule

Add Selected

Select	Vaccine Group	Earliest Date	Recommended Date	Overdue Date	Latest Date
☑	COVID-19	11/10/2022	11/10/2022	**11/10/2022**	05/09/2027
☐	DTP/aP	05/10/2026	05/10/2026	05/09/2029	05/09/2029
	HepA		**Complete**		
	HepB		**Complete**		
	Hib		**Complete**		
☑	Influenza	11/10/2022	11/10/2022	**12/10/2022**	
☐	Measles	**07/03/2023**	05/10/2026	05/10/2029	

☐	Mum	**07/03/2023**	05/10/2026	10/2029
	PCV		**Complete**	
☐	Polio	05/10/2026	05/10/2026	05/10/2029
	Rotavirus		**Maximum Age Exceeded**	
☐	Rubella	**07/03/2023**	05/10/2026	05/10/2029
☐	Varicella	**08/28/2023**	05/10/2026	05/10/2029

Copyright © 1999-2026 State of Wisconsin. All rights reserved

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/ Guardian Name: _____ (first / middle / last)

Parent/ Guardian Contact Information:

Daytime phone number: _____

Evening phone number: _____

Cell phone number: _____

Child's Name: BRIXTON (first) T. (middle) Baker (last)

Date of Birth: 05/10/22 **Gender:** ☒ Male ☐ Female

Child's Home Address: 900 Coleman ST SW (street) ATLANTA (city) GA (state) 31310 (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

D Lawson 1/30/24
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

D Lawson 1/30/24
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:

Morehouse Healthcare
Comprehensive Family Healthcare Center
455 Lee Street, 2nd Floor
Atlanta, Georgia 30310

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☒ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE
Dr. Lauren Cooper	

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
Family Medicine	404-752-1000	01/30/2026

ADDRESS: 455 Lee St SW, 2nd Floor, Atlanta, GA 30310

EXAMINATION RESULTS

HEIGHT	WEIGHT	BLOOD PRESSURE
40.94 inches	37 lbs/oz	107/69

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin – Mild eczema	✓		Mouth/Teeth/ Oral Health Assessment	✓		Genitalia	✓	
Head	✓		Throat	✓		Neurologic	✓	
Neck	✓		Chest	✓		Extremities	✓	
Lymph Nodes	✓		Lungs	✓		Motor Ability	✓	
Eyes	✓		Heart	✓		Psychological	✓	
Ears	✓		Back	✓		Speech	✓	
Nose	✓		Abdomen	✓		Developmental	✓	
						Behavioral	✓	

Vision Acuity	Right	Left	Both	Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date 1/30/26	20/20	20/20	20/20	Date	1/30/26	1000 Hz	PASS dB	PASS dB
Test Type				Test Type		2000 Hz	PASS dB	PASS dB
						3000 Hz	PASS dB	PASS dB
						4000 Hz	PASS dB	PASS dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
06/05/2023	13.5	☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	
06/05/2023	<1.0	☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☒ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS			DATE READ
	mm	☐ Non Significant	☐ Significant	

DATE OF CHEST X-RAY			RX DATE
	☐ Normal	☐ Abnormal	

Lead Risk Assessment

☐ At Risk ☒ No Risk

Immunizations

GIVEN TODAY ☒ Yes ☐ No List: See handout

Provided	Yes	No
Anticipatory Guidance Provided	X	
Fluoride Varnish Applied		X

Diagnosis/Abnormal Findings

Treatment/Restrictions/Recommendations for School

Does the child have asthma? ☐ Yes ☒ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☒ No **(If yes, Medication Administration form needed)**

Child is physically and emotionally able to participate in program ☒ Yes ☐ No **(If no, please explain in space above)**

TYPE OF MEDICATION AND PURPOSE

7/18 **Distribution:** **White – Child's File** **Canary – Parent**

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form:_____ **Staff Name:**_____

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME: Brixton Baker SEX: M BIRTHDATE: 5/10/22

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No ____ Unknown ____ Yes ____
   - Fluoridated water? No ____ Unknown ____ Yes ____
   - Fluoride Supplement diet? (tablets ____, liquid ____) No ____ Unknown ____ Yes ____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

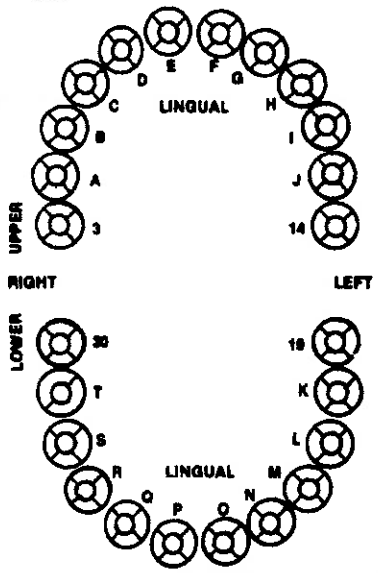
PART I. TO BE COMPLETED BY HEAD START STAFF

3. CHILD (✓ HAS, ___ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name _____ Date last visit 9/11/25
4. CHILD (___ IS, ___ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name _____
5. CHILD (___ IS, ___ IS NOT) RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider _____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party) _____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)
		Oral evaluation		9	11	25	D0150	$120
		Child Prophy		9	11	25	D1120	$95
		Fluoride		9	11	25	D1206	$62

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☑ E. NO PROBLEMS

Kids Dental Studio
1039 Grant St. Ste B11
Atlanta, Ga 30315
(470) 747-7888

Approximate number of visits _____. Approximate cost _____

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___ is, ___ is not) complete. If not, explain here, as well as items checked.

   _____

   _____

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature _____ Date 2/12/26

INTERVIEWER: GO TO FORM 6

Document: Certified Birth Certificate

Filename: test_birth_cert.pdf


GEORGIA
DRIVER'S LICENSE
DL
USA
GA
DRIVER'S LICENSE
Governor
Commissioner:
4d DL NO. 058257135
3 DOB 05/10/1983
9 CLASS C
4b EXP 05/10/2033
2 QUINAY ALICIA
1 BAKER
8 1079 REGENT ST SW
ATLANTA, GA 30310-5039
FULTON
12 REST B
9a END NONE
4a ISS 09/10/2025
15 SEX F
18 EYES BRO
16 HGT 5'-05"
17 WGT 170 lb
5 DD 612045232380020000

Georgia Department of Public Health

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: Brixton Baker
first middle last

Date of Birth: 05 / 10 / 2022 **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

Taylor Addison, DDS 04/08/2026
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:

Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

Who is required to file this Form 3300? The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

What is the purpose of Form 3300? Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

What screenings are required? Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

Who can conduct the screenings? Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietician or a school registered nurse. It is not necessary that the same person conduct all four screenings.

What does "BMI" and "BMI%" mean? "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietician for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

What should a parent do if the "needs further evaluation" box is checked? "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

What if a Form 3300 was previously filed for the child at another school? It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Clark, Lilian Mae	**State Student ID:** 2609517
Date of Birth: 07/20/22	**Classroom:** Room 7
Parent / Guardian: Shannon Fairorth & Timothy Clark	**Contact Phone:** 267-481-1334 / 470-213-8912

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (3 PENDING)
Remaining items needed for 100% compliance: **Parent Photo ID; Signed Appendix D Roster Form; CACFP Income Statement**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Clark_Lilian_Mae.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Lilian_Clark.pdf	1	✓ SIGNED
3	**Registration Application**	[Untitled]_9e5f17.pdf	13	✓ ON FILE
4	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	lilian 3300 form.pdf	1	✓ VERIFIED
5	**Proof of Georgia Residency**	Home Insurance- Proof of Residency.pdf	2	✓ VERIFIED
6	**Child Social Security Card**	Lilian (Lily) Clark- SS Card.pdf	1	✓ VERIFIED
7	**Form 3231 (Georgia Certificate of Immunization)**	lilian 3300 form.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609517
Student Name: Clark, Lilian Mae	**Date of Birth:** 07/20/22
Parent(s)/Guardian: Shannon Fairorth & Timothy Clark	**Phone:** 267-481-1334 / 470-213-8912

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
[ACTION NEEDED]	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ RECEIVED	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ RECEIVED	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ RECEIVED	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
[ACTION NEEDED]	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609517
Scan the QR code or click the link above. Use child's Date of Birth (**07/20/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Clark, Lilian Mae** Parent Signature: _____ Date: _____

Georgia's Pre-K Program Roster Information Form

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Lilian
Legal Middle Name: Mae
Legal Last Name: Clark
Name Suffix (Jr,II,III):
Name Child is Called:
Child's Social Security: 692-50-5429
Date of Birth: 07/20/2022
Gender: M [ ] F [X]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Fairorth
First Name: Shannon
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: sclark@cviga.org
Zip Code: 30281

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

Parent/Guardian Signature

2026-07-31

Date

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-2027 School Year

PROVIDER LEGAL NAME:

(This section to be completed by the provider)

SCHOOL/SITE NAME: KIDAZZLE-SUMMIT

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)

CHILD'S LAST NAME: CLARK

CHILD'S FIRST NAME: LILLIAN

CHILD'S MIDDLE NAME: MAE NAME SUFFIX: (i.e. Jr, Sr, II, III)

CHILD'S SOCIAL SECURITY#: 692-50-5429 D.O.B. (MM/DD/BY): 7/22/22 SEX: [ ]M [X]F

HOME ADDRESS (*Do not enter PO Box Info*): 165 New Flood Rd COUNTY: Henry

CITY: Stockbridge STATE: GA ZIP: 30281 HOME PHONE: (404) 404-602-4276

If the Student is transferring from another Pre-K, please provide the following:

Previous School Name: Arthur Blank YMCA Last Date in Attendance: 8/14/26

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 - LAST NAME: FAIRCRTH FIRST: SHANNON MIDDLE INITIAL: M

Home Address (*If different from child*): NIA

City: State: Zip:

Home Phone: ( ) 404-602-4276 Cell Phone: ( ) 267-481-1334

Email Address: sclark@cviga.org

Place of Employment: Center for the Visually Impaired Work Phone: ( ) 404-602-4276

Address: 739 W Peachtree St NW

City: Atlanta State: GA Zip: 30308

Parent/Guardian #2 - LAST NAME: CLARK FIRST: TIMOTHY MIDDLE INITIAL: R

Home Address (*If different from child*): NIA

City: State: Zip:

Home Phone: ( ) Cell Phone: ( )

Email Address: clarktimothy@hotmail.com

Place of Employment: DaVita Kidney Care Work Phone: (470) 213-5912

Address: (Various locations)

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.	Sharon Charles	grandmother	678-485-0096		sharlajane@hotmail.com
2.	Rebecca Hernandez	grandmother	215-272-0068		beccabee1966@hotmail.com

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:** 8/13/26

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. Shayla Charles	1564 Overlook Pass Rd, 30655	grandmother	678.485.[illegible]6
2. Rebecca Hernandez	19 Versaggi Dr, 32080	grandmother	215-272-0[illegible]
3. Linda Ballinger	842 Ventura Way SW, 30331	770.826.9512	friend
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): McDonough Pediatrics
DATE OF LAST FULL HEALTH SCREENING: February 2026 PHONE: (~~770~~) 957.5626

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

N/A

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

N/A

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:

N/A

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: 8/13/26

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, Lily Clark, 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: 8/13/26

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 8/17/26 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Lilian (Lily) Clark
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ 100 **per week.**

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Lunch Afternoon Snack Dinner (school age only)

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: _____

Date: 5/13/26

Facility Administrator Signature: _____

Date: 5/15/24

Georgia Dept of Early Care and Learning

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): ___/___/___		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security # ___-___-___	DOB (M/D/Y): ___/___/___	Gender: M ☐ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): ___/___/___	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	Other ☐
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☐ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☐ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☐ **No**

_____

Parent/Guardian Signature **Date**

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
   (i.) Provide information about the benefits of regular attendance.
   (ii.) Support families to promote the child's regular attendance.
   (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
   (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 8/13/26

Administrative Signature: _____ **Date:** 8/18/26

Teacher Signature: _____ **Date:** _____

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number | Local File Number | 1. State File Number: **2022GA000067505**

2.CHILD'S NAME: FIRST 3.MIDDLE 4 LAST 5 JR.,III,ETC.	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
LILIAN MAE CLARK	**FEMALE**	**07/20/2022**

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
06:17 PM	**SINGLE**	

11 CITY TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
ATLANTA	**PIEDMONT HOSPITAL**
13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH: **FULTON**

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST	18.MAIDEN (Last Name)
SHANNON MAE FAIRORTH	**FAIRORTH**

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
05/25/1991	**PENNSYLVANIA**	**GEORGIA**	**BARROW**

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
WINDER	**219 WHISTLEVILLE COURT**

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
219 WHISTLEVILLE COURT WINDER GEORGIA 30680	**NO**

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A. ,Name Country)
TIMOTHY RYAN CLARK	**12/29/1985**	**ARIZONA**

32a. INFORMANT'S NAME (Type or Print)	32b RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
SHANNON MAE FAIRORTH	**MOTHER**	**YES**

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature) Electronically signed by	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
/S/ CYNTHIA JOHNSON	**07/24/2022**	(Name) **VANESSA BIGGS** 37.(Title) **MD**

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip)
(Name) **CYNTHIA JOHNSON** (Title) **HOSPITAL STAFF**	**47400**	**1968 PEACHTREE ROAD NW ATLANTA GEORGIA 30309**

41. REGISTRAR (Signature) Electronically signed by	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
/S/ CYNTHIA M. BUSKEY	**07/24/2022**

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE **Form 3901A (Rev. 01/2013)**

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS

Any reproduction of this document is prohibited by statute. Do not accept unless on security paper with seal of Vital Records clearly embossed. Chapter 31-10, Code of Georgia as amended.

10880748

DEC 12 2024

State Registrar

BY Cynthia M. Buskey

S2541683

STATE OFFICE VITAL RECORDS

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

STATE OF GEORGIA 1776

Form 3972 (Rev.5/15)

VOID IF ALTERED OR COPIED

Foremost
9797 Springboro Pike, Suite 300
Dayton OH 45448-0002

FOREMOST®
A Farmers Insurance® Company

Please do not send payment to the address above.

Foremost

Economy Preferred Insurance Company
Policy Number: Homeowners H7994355230

Georgia Housing and Finance Authority CO State Home Mortgage
60 Executive Park South NE
Atlanta GA 30329-2296

RE: SHANNON M FAIRORTH
103 New Hood Rd
Stockbridge GA 30281-6706

Loan Number:

Property Located at:
103 New Hood Rd
Stockbridge GA 30281-6706

This evidence of insurance is issued as a matter of information only and confers no rights upon the additional interest. This evidence does not amend, extend, or alter the coverage, terms, exclusions, or conditions afforded by the policy referenced herein.

The policy listed above has been issued to the Named Insured for the policy period shown.

Effective Date: 06/30/2026 Expiration Date: 06/30/2027

Policy Type: Homeowners **Annual Premium**: $1,966.00

Mail Payments to:
Foremost
PO Box 4093
Carol Stream, IL 60197-4093

Coverage on Real Property	**Amount of Insurance**
Dwelling	$497,560
Private Structures	$24,878 (20%)
Deductible	$5,000
Windstorm or Hail	2%

Building Property Loss Settlement
Extended Protection on Buildings

Foremost
Economy Preferred Insurance Company
Policy Number: Homeowners H7994355230

IMPORTANT NOTICE - RIGHTS AND DUTIES OF A MORTGAGEE

What you need to know

These rights and duties of a mortgagee are contained within our countrywide policy form. We will comply with state requirements in any state where statute or regulation requires a modification to our policy form.

A. If a mortgagee is named in the Declarations, any payment for loss under Coverage A or B will be made to the mortgagee and the insured, as their interests appear. If more than one mortgagee is named, payment will be made in the order of priority of the mortgagees.

B. The interest of the mortgagee under this policy will not be affected by any action or neglect by the insured.

C. If the mortgagee makes a claim directly to us for loss to covered real property on the **residence premises**, all terms of this policy apply to the mortgagee. We do not provide coverage unless the mortgagee:
   1. notifies us of any change of ownership, occupancy, or increase in hazard within a reasonable time after the mortgagee was made aware;
   2. pays upon demand any premium due if the insured fails to do so; and
   3. submits a signed, sworn statement of loss within 60 days after our request.

D. If this policy is cancelled by us, the mortgagee will be given notice at least 10 days* before the date cancellation takes effect.

E. If we pay the mortgagee for any loss and deny payment to the insured:
   1. we obtain all the rights that the mortgagee has under the mortgage on the property to the extent of our payment; or
   2. at our option, we may pay to the mortgagee the whole principal on the mortgage and any interest due. In this event, we may receive a full assignment and transfer of the mortgage and all securities held as collateral for the mortgage debt.

F. Subrogation will not impair the right of the mortgagee to recover the full amount of the mortgagee's claim.

*In any state where statute or regulation requires more than 10 days notice to the mortgagee, we will comply with the state requirements.

We're here to help

If you have any additional questions or need more information, please call us at 678-494-4511.
U S STANDARD INS CO
1320 OAKSIDE DR STE 101
CANTON, GA 30114-2475

Thank you for helping us service our customers.

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

CLARK, LILIAN MAE
Child's Name (Last name, First name)

07 | 20 | 2022
Birthdate

07 | 01 | 2034
Date of Expiration
(Next required immunization or review of medical exemption due.)

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	10 24 22	11 22 22	01 24 23	10 24 23	07 27 26		5				
Polio	10 24 22	11 22 22	01 24 23	10 24 23	07 27 26		5				
Hepatitis B	07 20 22	10 24 22	01 24 23				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	10 24 22	11 22 22	01 24 23	10 24 23			4				
PCV (Under Age 5)	10 24 22	11 22 22	01 24 23	08 02 23			4				
Measles	08 02 23	07 27 26					2				
Mumps	08 02 23	07 27 26					2				
Rubella	08 02 23	07 27 26					2				
Hepatitis A (Born on/after 1/1/06)	08 02 23	02 13 24					2				
Varicella	10 24 23	07 27 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	10 24 22	11 22 22	01 24 23				3				
HPV							0				
Influenza	10 24 23	02 13 24	02 19 25				3				
Td (booster)							0				
Men-B							0				

Note: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

McDonough Pediatrics, P.C.
(770) 957-8626
101 Regency Park Dr Suite 140
McDonough, GA 30253

Michelle Shah

7/27/20

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: Lilian Clark
first middle last

Date of Birth: 07 / 20 / 2022 **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:

Not Applicable-Dental ONLY

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:

Not Applicable-Dental ONLY

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

05/15/2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Dentistry For Children Corporate Service Center
1350 Spring Street NW, 6th Floor
Atlanta, GA 30309
770-692-1000

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:

Not Applicable-Dental ONLY

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:

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: Lilian Clark
first middle last

Date of Birth: 7/20/22 **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

_____ 2/10/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

McDonough Pediatrics, P.C.
101 Regency Park Drive #140
McDonough, GA 30253
(770) 957-8626

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

_____ 2/10/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

McDonough Pediatrics, P.C.
101 Regency Park Drive #140
McDonough, GA 30253
(770) 957-8626

DENTAL

- ☒ Unable to screen (explain why below)

- ☐ Normal appearance
- ☐ Needs further evaluation
- ☐ Emergency problem observed
- ☐ Under professional care (explained 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: 38.5in Weight: 36lbs
BMI: 17.07 BMI%: 87%

- ☐ 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

_____ 2/10/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

McDonough Pediatrics, P.C.
101 Regency Park Drive #140
McDonough, GA 30253
(770) 957-8626

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental	XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Nutrition			

Student support services initiated on:

Screeners' Comments:

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: Lilian Clark
first middle last

Date of Birth: 07 / 20 / 2022 **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:

Not Applicable-Dental ONLY

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:

Not Applicable-Dental ONLY

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


05/15/2026

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Dentistry For Children Corporate Service Center
1350 Spring Street NW, 6th Floor
Atlanta, GA 30309
770-692-1000

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:

Not Applicable-Dental ONLY

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:

DPH Form 3300 Rev. 2013

Foremost
9797 Springboro Pike, Suite 300
Dayton OH 45448-0002

FOREMOST®
A Farmers Insurance® Company

Please do not send payment to the address above.

Foremost

Economy Preferred Insurance Company
Policy Number: Homeowners H7994355230

Georgia Housing and Finance Authority CO State Home Mortgage
60 Executive Park South NE
Atlanta GA 30329-2296

RE: SHANNON M FAIRORTH
103 New Hood Rd
Stockbridge GA 30281-6706

Loan Number:

Property Located at:
103 New Hood Rd
Stockbridge GA 30281-6706

This evidence of insurance is issued as a matter of information only and confers no rights upon the additional interest. This evidence does not amend, extend, or alter the coverage, terms, exclusions, or conditions afforded by the policy referenced herein.

The policy listed above has been issued to the Named Insured for the policy period shown.

Effective Date: 06/30/2026 Expiration Date: 06/30/2027

Policy Type: Homeowners **Annual Premium**: $1,966.00

Mail Payments to:
Foremost
PO Box 4093
Carol Stream, IL 60197-4093

Coverage on Real Property	**Amount of Insurance**
Dwelling	$497,560
Private Structures	$24,878 (20%)
Deductible	$5,000
Windstorm or Hail	2%

Building Property Loss Settlement
Extended Protection on Buildings

IMPORTANT NOTICE - RIGHTS AND DUTIES OF A MORTGAGEE

What you need to know

These rights and duties of a mortgagee are contained within our countrywide policy form. We will comply with state requirements in any state where statute or regulation requires a modification to our policy form.

A. If a mortgagee is named in the Declarations, any payment for loss under Coverage A or B will be made to the mortgagee and the insured, as their interests appear. If more than one mortgagee is named, payment will be made in the order of priority of the mortgagees.

B. The interest of the mortgagee under this policy will not be affected by any action or neglect by the insured.

C. If the mortgagee makes a claim directly to us for loss to covered real property on the **residence premises**, all terms of this policy apply to the mortgagee. We do not provide coverage unless the mortgagee:
   1. notifies us of any change of ownership, occupancy, or increase in hazard within a reasonable time after the mortgagee was made aware;
   2. pays upon demand any premium due if the insured fails to do so; and
   3. submits a signed, sworn statement of loss within 60 days after our request.

D. If this policy is cancelled by us, the mortgagee will be given notice at least 10 days* before the date cancellation takes effect.

E. If we pay the mortgagee for any loss and deny payment to the insured:
   1. we obtain all the rights that the mortgagee has under the mortgage on the property to the extent of our payment; or
   2. at our option, we may pay to the mortgagee the whole principal on the mortgage and any interest due. In this event, we may receive a full assignment and transfer of the mortgage and all securities held as collateral for the mortgage debt.

F. Subrogation will not impair the right of the mortgagee to recover the full amount of the mortgagee's claim.

*In any state where statute or regulation requires more than 10 days notice to the mortgagee, we will comply with the state requirements.

We're here to help

If you have any additional questions or need more information, please call us at 678-494-4511.

U S STANDARD INS CO
1320 OAKSIDE DR STE 101
CANTON, GA 30114-2475

Thank you for helping us service our customers.


SOCIAL SECURITY
692-50-5429
THIS NUMBER HAS BEEN ESTABLISHED FOR
LILIAN MAE
CLARK
SIGNATURE
08/20/2026
USA

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: Lilian Clark
first middle last

Date of Birth: 07 / 20 / 2022 **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:

Not Applicable-Dental ONLY

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:

Not Applicable-Dental ONLY

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


05/15/2026

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Dentistry For Children Corporate Service Center
1350 Spring Street NW, 6th Floor
Atlanta, GA 30309
770-692-1000

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:

Not Applicable-Dental ONLY

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:

DPH Form 3300 Rev. 2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Coss-DeJessus, Zoe Selene	**State Student ID:** 2609523
Date of Birth: 08/29/22	**Classroom:** Room 7
Parent / Guardian: Michele A. DeJesus & Jeffrey Coss	**Contact Phone:** 978-914-1108 / 978-390-5351

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Coss-DeJessus_Zoe_Selene.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_746cc8.pdf	8	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	image.jpg	1	✓ VERIFIED
4	**Form 3231 (Georgia Certificate of Immunization)**	image.jpg	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609523
Student Name: Coss-DeJesus, Zoe Selene	**Date of Birth:** 08/29/22
Parent(s)/Guardian: Michele A. DeJesus & Jeffrey Coss	**Phone:** 978-914-1108 / 978-390-5351

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ RECEIVED	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609523

Scan the QR code or click the link above. Use child's Date of Birth (**08/29/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Coss-DeJesus, Zoe Selene** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box → 2026-27

Pre-K Registration Form School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDAZZLE-Summit

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Coss-DeJesus			
CHILD'S FIRST NAME: Zoe			
CHILD'S MIDDLE NAME: Selene	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 694774758	D.O.B. (MM/DD/BY): 2022-08-2	SEX:	M ☑ F
HOME ADDRESS (*Do not enter PO Box Info*): 1798 merry oak rd		COUNTY:	
CITY: Marietta	STATE: GA	ZIP: 30008	HOME PHONE: (9789141108

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: Dejesus	FIRST: Michele	MIDDLE INITIAL: A
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: Coss	FIRST: Jeffrey	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )9783905351	
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.	Margarita	Grandma	9788761401		Margarita Martínez-
2.	martinez				1125@hotmail.com

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.

Michele Dejesus

Signature Parent/Guardian: Michele Dejesus **DATE:** 2026-07-21

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.	Margarita martinez	1798 merry oak rd sw Marietta	Grandma	
2.	Jeffrey Coss	30008	Father	
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.

Michele Dejesus

SIGNATURE (Parent/Guardian): Michele Dejesus

DATE: 2026-07-21

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, Zoe Coss, 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 Michele Dejesus

SIGNATURE (Parent/Guardian): Michele Dejesus

DATE: 2026-07-21

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-31 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday -- Friday.

Zoe Coss-DeJesus

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay: _____ Reg. Fee: $50.00
Total Weekly Tuition: 90

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑ **Breakfast** ☑ **Lunch** ☑ **Afternoon Snack** ☑ **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Michele Dejesus

Parent/Guardian Signature: Michele Dejesus

Date: 2026-07-21

Facility Administrator Signature: [signature]

Date: 8/3/24

Georgia Dept of Early Care and Learning

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-07-21

CHILD INFORMATION:

Legal First Name: Zoe	Name Suffix (Jr,II,III):
Legal Middle Name: Selene	Name Child is Called:
Legal Last Name: Coss-DeJesus	
Child's Social Security # 694774758	DOB (M/D/Y): 2022-08-29
Choose Not to Provide SSN [ ]	Date enrolled in Pre-K (M/D/Y): 2026-08-03

PARENT/GUARDIAN INFORMATION:

Last Name: DeJesus	First Name: Michele
Relationship: Mother [x] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]	
Email Address: Mdejesusmartinez2025@gmail.com	Zip Code: 30008

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[x] **Hispanic/Latino** | **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[x] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

f. **Decline to Answer**

3. What is your child's primary language?

English

[x] **A language other than English**

3.a. Which language is spoken in the child's home (other than English)? Michele Dejesus

4. Was your child born as a:

[x] **Single Birth (1)**

Twin (2)

Triplet (3)

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

Yes [x] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)

6. Does your child receive any of the following services?

Childcare and Parent Services (CAPS)

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

Supplemental Nutrition Assistance Program (SNAP)

Medicaid

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

Yes [x] **No**

Michele Dejesus

Parent/Guardian Signature

2026-07-21

Date

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

The Commonwealth of Massachusetts

1235377

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

CERTIFICATE OF LIVE BIRTH

State File #	**2022 045391**
Registered #	**13835**

07012019

BIRTHPLACE

BRIGHAM AND WOMEN'S HOSPITAL
75 FRANCIS STREET
BOSTON, MASSACHUSETTS 02115

Date of Birth	**AUGUST 29, 2022**
Sex	**FEMALE**
Time of Birth	**12:49 AM**
Plurality	**SINGLE**
Birth Order	**—**

CHILD

First Name	**ZOE**
Middle	**SELENE**
Surname	**COSS-DEJESUS**

PARENT

First Name	**MICHELE**
Middle	**ALTAGRACIA**
Surname	**DEJESUS**
Surname at Birth or Adoption	**DEJESUS**
Birthplace	**MANHATTAN, NEW YORK**
Date of Birth	**NOVEMBER 20, 1997**

PARENT

First Name	**JEFFREY**
Middle	**ALEXANDER**
Surname	**COSS**
Surname at Birth or Adoption	**COSS**
Birthplace	**LAWRENCE, MASSACHUSETTS**
Date of Birth	**NOVEMBER 26, 1995**

Residence **31 CHESTER STREET APT. 1, LAWRENCE, MASSACHUSETTS 01843**

Certifier Name/Title **KATHERINE YILIN WANG, MD**
Type **AT-BIRTH**
Lic.# **287568**

Date of Record **SEPTEMBER 09, 2022**
Amendment Date

Patricia A McMahon

REGISTRAR, CITY OF BOSTON

DATE ISSUED: **NOVEMBER 16, 2022**

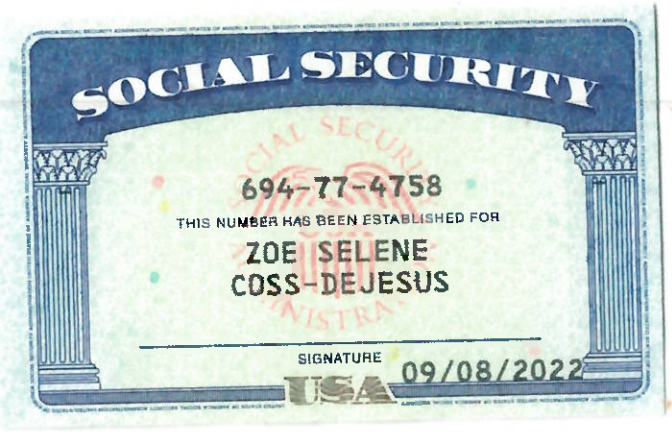
I, the undersigned, hereby certify that I am the Registrar of the City of Boston; that as such I have custody of the records of birth, marriage, and death required by law to be kept in my office; and I do hereby certify that the above is a true copy from said records, as held in the Commonwealth's central vital records information repository.

Patricia A McMahon

Registrar
City of Boston

ILLEGAL TO ALTER OR REPRODUCE

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED


SOCIAL SECURITY
694-77-4758
THIS NUMBER HAS BEEN ESTABLISHED FOR
ZOE SELENE
COSS-DEJESUS
SIGNATURE
09/08/2022
USA

FORM 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

DPH GEORGIA DEPARTMENT OF PUBLIC HEALTH

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

Child's Name (First, Middle, Last): Zoe Selene Coss-DeJesus

Parent/Guardian Name (First, Middle, Last): Michele A DeJesus

Date of Birth: 8-29-22 Gender: ☐ Male ☒ Female

Parent/Guardian Contact Information:

Home Address: 1798 merry oaks Marietta GA 30008 (Street / City / State / Zip Code)

Primary Phone#: 973-914-1108 Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☑ Distance visual acuity chart (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ Instrument-based/Photoscreener (**Alternative method; see guidance below)

Results:
☑ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☑ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

9/3/26
Erica van Cotten MD
Screener's Signature Date

I certify that the above screening was completed or attempted for this child.

Contact Information:

Cobb Pediatrics
3405 Dallas Hwy SW, Bldg. 300
Marietta, GA 30064

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☑ Pure tone audiometry (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ Automated Otoacoustic Emissions (**Alternative method; see guidance below)

Results:
☑ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☑ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

9/3/26
Erica van Cotten MD
Screener's Signature Date

I certify that the above screening was completed or attempted for this child.

Contact Information:

Cobb Pediatrics
3405 Dallas Hwy SW, Bldg. 300
Marietta, GA 30064

DENTAL

Results:
☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

Screener's Signature Date

I certify that the above screening was completed or attempted for this child.

Contact Information:

NUTRITION

Results:
Height: 40 Weight: 30
BMI: 15.9 BMI%: 64

☑ 5th to 84th percentile - Appropriate for age
☐ <5th percentile - Needs further evaluation
☐ ≥85th percentile - Needs further evaluation
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☑ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

9/3/26
Erica van Cotten MD
Screener's Signature Date

I certify that the above screening was completed or attempted for this child.

Contact Information:

Cobb Pediatrics
3405 Dallas Hwy SW, Bldg. 300
Marietta, GA 30064

Vision and Hearing Screening Method Guidance:

* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

DPH Form 3300 Rev. 2026

Rev. 07/2020

Georgia Department of Public Health

CERTIFICATE OF IMMUNIZATION

Form **3231**

COSS-DEJESUS, ZOE
Child's Name (Last name, First name)

08/29/2022
Birthdate

DEJESUS, MICHELE
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

8 | 29 | 2033
Date of Expiration
(Next required immunization or review of medical exemption due.)

Complete For K through 6th Grade (X) (Fill in X)
Child must be >= 4 years and have met all requirements for school attendance.

Complete For 7th through 10th Grade ( ) (Fill in X)
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

Complete For 11th Grade and higher ( ) (Fill in X)
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	11/07/2022	01/09/2023	03/23/2023	12/05/2023	09/03/2026		5				
Polio	11/07/2022	01/09/2023	03/23/2023	12/05/2023	09/03/2026		5				
Hepatitis B	08/29/2022	11/07/2022	01/09/2023	03/23/2023			4		X		
Tdap							0				
MCV4							0				
HIB (Under Age 5)	11/07/2022	01/09/2023	03/23/2023	12/05/2023			4				
PCV (Under Age 5)	11/07/2022	01/09/2023	03/23/2023	08/31/2023			4				
Measles	08/31/2023	09/03/2026					2		X		
Mumps	08/31/2023	09/03/2026					2		X		
Rubella	08/31/2023	09/03/2026					2		X		
Hepatitis A (Born on/after 1/1/06)	02/29/2024	09/03/2024					2		X		
Varicella	08/31/2023	09/03/2026					2		X		
Recommended Vaccines (For Information Only)											
Rotavirus	11/07/2022	01/09/2023					2				
HPV							0				
Influenza	03/23/2023	04/26/2023	12/05/2023	09/03/2024			4				
Td (booster)							0				
Men-B							0				

Notes:

A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department
Erika Van Putten, M.D., F.A.A.P
Cobb Pediatrics, 3405 Dallas Hwy SW, #300, Marietta, GA 30064
770-425-5331

Erika van Putten, MD FAAP 09/03/2026

Certified by (Signature/Signature Stamp) **Date of Issue**

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Falcon-Castillo, Oswaldo Jr	**State Student ID:** 2609487
Date of Birth: 06/06/22	**Classroom:** Room 7
Parent / Guardian: Sharonda Walker (Shawanna Molden) & Oswaldo Falcon	**Contact Phone:** 404-587-8951

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Falcon-Castillo_Jr_Oswaldo.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_0ec7de.pdf	12	✓ ON FILE
3	**Child Social Security Card**	image2.jpeg	1	✓ VERIFIED
4	**CACFP Income Eligibility Statement (IES)**	image2 (1).jpeg	1	✓ VERIFIED
5	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	image.jpg	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Date: September 15, 2026	**Classroom:** Room 7 (Site ID: 33915)
Student Name: Falcon-Castillo Jr., Oswaldo	**Date of Birth:** 06/06/2022
Parent(s)/Guardian: Sharonda Walker (Shawanna Molden) & Oswaldo Falcon	**Phone:** 404-587-8951

Dear Parent/Guardian,

Under **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all students attending Georgia's Pre-K Program must have complete, state-mandated documentation on file at the center. During our compliance and data collection audit, the documentation below was identified as missing or incomplete for your child.

ACTION REQUIRED — OUTSTANDING ITEMS NEEDED:

- **Child Physical SSN Card (30-day waiver active)**
- **Form 3300 (Ear, Eye, Dental Screening)**
- **Proof of Income (W-2 or check stubs)**

Important Guidelines for Required Documents:

- **Form 3300 (Screening):** Must include all four components (Ear/Hearing, Eye/Vision, Dental, and Nutrition). Blood pressure and lead screening must be recorded.
- **Form 3231 (Immunizations):** Must be a current Georgia Certificate of Immunization with valid expiration date or marked 'Complete for School'.
- **Proof of Residence:** Current gas, electric, or water utility bill (dated within 30 days) or valid lease agreement showing matching home address.
- **Social Security / 30-Day Waiver:** If an official 30-day waiver was signed, the physical card or proof of card order from SSA must be presented before the grace period expires.

COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please submit clear, readable copies immediately to ensure your child's enrollment remains in active standing with Georgia DECAL.

- **Email Submissions:** Send scanned copies or clear photos directly to **Ms. Karen Harris** at: karenharris@kidazzle.com
- **In-Person Submissions:** Hand-deliver original documents or copies to the Administrative Front Desk.
- **Questions / Support:** Call Ms. Harris at **(404) 753-8884** or mobile at **(404) 884-1483**.

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Falcon-Castillo Jr., Oswaldo** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write school year in the box →

Pre-K Registration Form

2026/2027 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	– Summit

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)

CHILD'S LAST NAME: Falcon-Castillo Jr.			
CHILD'S FIRST NAME: Oswaldo			
CHILD'S MIDDLE NAME:	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 442-55-6106	D.O.B. (MM/DD/BY): 2022-06-0	SEX: ☑ M	F
HOME ADDRESS (*Do not enter PO Box Info*): 400 W Peachtree St. NW Unit 2612	COUNTY:		
CITY: Atlanta	STATE: GA	ZIP: 30308	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: Molden	FIRST: Shawanna	MIDDLE INITIAL: N
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( ) 678-315-9298	
Email Address: Shawanna.molden@gmail.co		
Place of Employment: Kaiser Permanente	Work Phone: ( )	
Address:		
City:	State:	Zip:
Parent/Guardian #2 - LAST NAME: Falcon-Castillo	FIRST: Oswaldo	MIDDLE INITIAL:
Home Address (*If different from child*):		
City: Douglasville	State: GA	Zip: 30135
Home Phone: ( )	Cell Phone: ( ) 678-899-2456	
Email Address:		
Place of Employment: Delta Airlines	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.	Julia Anderson	Grandmother	404-542-5692		
2.	Charlene Huff	Aunt	404-295-3409		

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.

Shawanna Molden

Signature Parent/Guardian: Shawanna Molden **DATE:** 2026-05-28

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. Oswaldo Falcon-Castillo		Father/678-899-2456
2. Jane Anderson		Grandmother/404-542-5692
3. Charlene Huff		Aunt/404-542-5692
4.		

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Lori Duckett

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:

Albuterol, Diary allergy, Eczema

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.

Shawanna Molden

SIGNATURE (Parent/Guardian): Shawanna Molden

DATE: 2026-05-28

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, Decline, 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: Shawanna Molden

SIGNATURE (Parent/Guardian): Shawanna Molden

DATE: 2026-05-28

KIDazzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-03 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Oswaldo Falcon-Castillo Jr.

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After Schoo Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑ **Breakfast** ☑ **Lunch** ☑ **Afternoon Snack** ☑ **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Shawanna Molden

Parent/Guardian Signature: Shawanna Molden

Date: 2026-05-28

Facility Administrator Signature: K Harris

Date: 7/10/26

Georgia Dept of Early Care and Learning

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y):		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security #	DOB (M/D/Y):	Gender: M | F |
Choose Not to Provide SSN [	Date enrolled in Pre-K (M/D/Y):	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother [Father	Grandparent	Guardian Other
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino | **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

f. **Decline to Answer**

3. What is your child's primary language?

English

A language other than English

3.a. Which language is spoken in the child's home (other than English)?

4. Was your child born as a:

Single Birth (1)

Twin (2)

Triplet (3)

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

Yes [**No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)

6. Does your child receive any of the following services?

Childcare and Parent Services (CAPS)

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

Supplemental Nutrition Assistance Program (SNAP)

Medicaid

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

Yes **No**

~~Shawanna Molden~~

Shawanna Molden

Parent/Guardian Signature

2026-05-28

Date

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.
   1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**
   2) A program must implement strategies to promote attendance. At minimum, a program must:
      (i.) Provide information about the benefits of regular attendance.
      (ii.) Support families to promote the child's regular attendance.
      (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
      (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.
   3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email:** karenharris@kidazzle.com
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Shawanna Molden

Parent(s) or Guardians Signature: Shawanna Molden **Date:** 2026-05-28

Administrative Signature: K. Harris **Date:** 7/10/26

Teacher Signature: _____ **Date:** _____

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:

(i.) Provide information about the benefits of regular attendance.

(ii.) Support families to promote the child's regular attendance.

(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,

(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

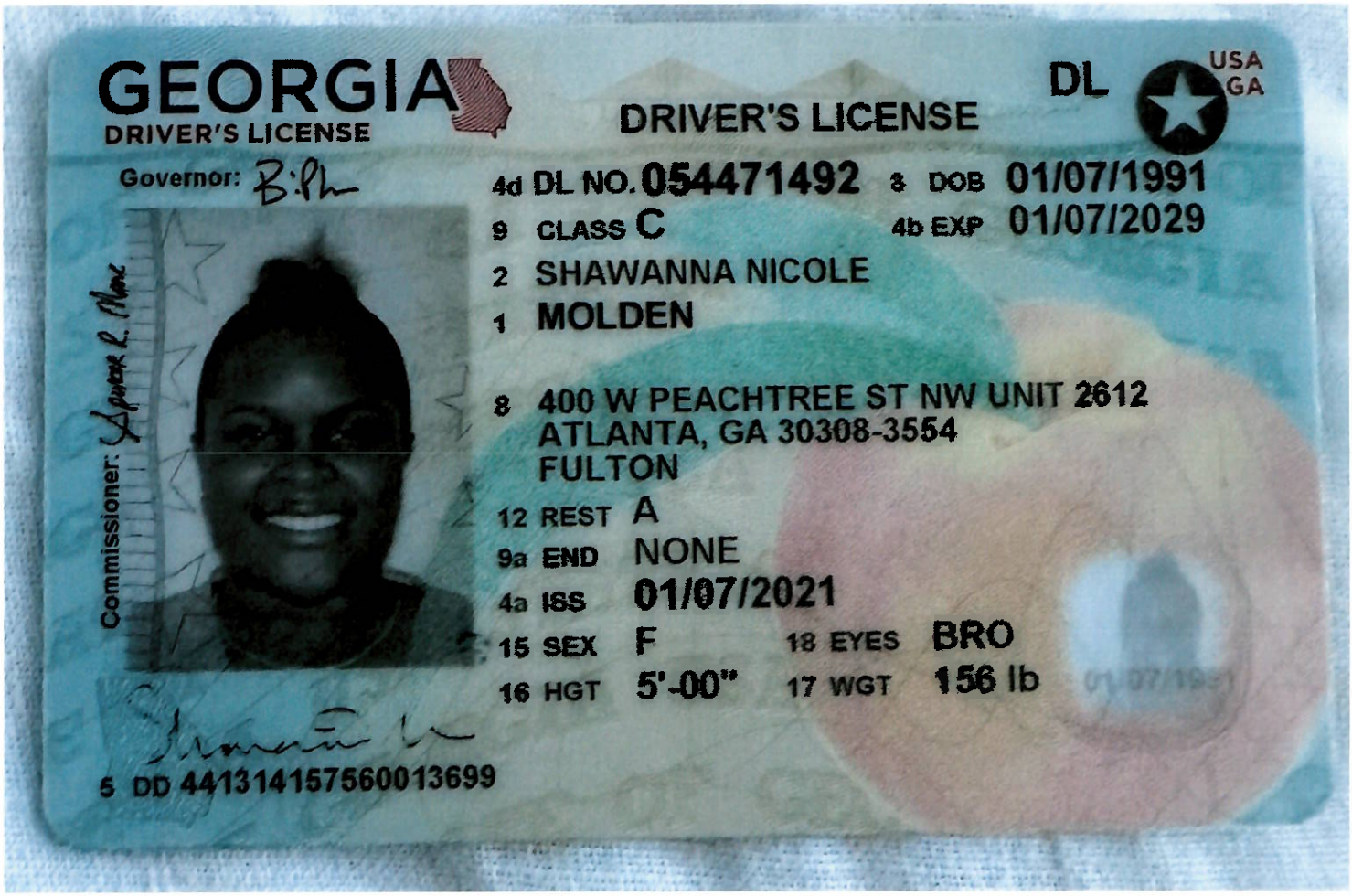
Shawanna Molden

Parent(s) or Guardians Signature: Shawanna Molden **Date:** 2026-05-28

Administrative Signature: _____ **Date:** 7/6/26

Teacher Signature: _____ **Date:** _____

Falcon


GEORGIA
DRIVER'S LICENSE
Governor:
Commissioner:
DRIVER'S LICENSE
DL
USA
GA
4d DL NO. 054471492
8 DOB 01/07/1991
9 CLASS C
4b EXP 01/07/2029
2 SHAWANNA NICOLE
1 MOLDEN
8 400 W PEACHTREE ST NW UNIT 2612
ATLANTA, GA 30308-3554
FULTON
12 REST A
9a END NONE
4a ISS 01/07/2021
15 SEX F
18 EYES BRO
16 HGT 5'-00"
17 WGT 156 lb
5 DD 441314157560013699

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH	Death Number	Local File Number	1. State File Number 2022GA000052930
2.CHILD'S NAME. FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC. OSWALDO FALCON-CASTILLO JR		6.SEX (M or F) MALE	7.DATE OF BIRTH (Mo., Day, Year) 06/06/2022
8.TIME OF BIRTH 05:37 PM	9. THIS BIRTH (Single, Twin, Triplet, Etc.) SINGLE	10.IF NOT SINGLE SPECIFY BIRTH ORDER	
11.CITY,TOWN, OR LOCATION OF BIRTH ATLANTA	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.) NORTHSIDE HOSPITAL		
13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH FULTON		
15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST SHAWANNA NICOLE MOLDEN		18.MAIDEN (Last Name) MOLDEN	
19.DATE OF BIRTH (Month,Day,Year) 01/07/1991	20.STATE OF BIRTH (If not U.S.A.,Name Country) ALABAMA	21.RESIDENCE - STATE GEORGIA	22. COUNTY FULTON
23. CITY,TOWN OR LOCATION ATLANTA		24.STREET AND NUMBER OF RESIDENCE 400 W PEACHTREE STREET NW APT 2612	
25.MOTHER'S MAILING ADDRESS 400 W PEACHTREE STREET NW APT 2612 ATLANTA GEORGIA 30308		26.RESIDENCE INSIDE CITY LIMITS? (yes or No) YES	
27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC. OSWALDO FALCON-CASTILLO		30.DATE OF BIRTH (Month,Day,Year) 10/11/1989	31.STATE OF BIRTH(If not U.S.A. ,Name Country) US VIRGIN ISLANDS
32a. INFORMANT'S NAME (Type or Print) SHAWANNA N MOLDEN	32b. RELATION TO CHILD MOTHER	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No) YES	
34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature) Electronically signed by /S/ CAMECIA TURNER		35. DATE SIGNED (Mo.,Day,Year) 06/12/2022	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print) (Name) ALYSSA DAYTON 37.(Title) MD
38. CERTIFIER (Type or Print) (Name) CAMECIA TURNER (Title) BIRTH CLERK	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip) 1000 JOHNSON FERRY ROAD ATLANTA GEORGIA 30342	
41. REGISTRAR (Signature) Electronically signed by /S/ CHRISTOPHER JP HARRISON		42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year) 06/12/2022	

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE Form 3901A (Rev. 01/2013)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept unless bearing seal and seal of Vital Records clearly embossed. Chapter 31-10, Code of Georgia as amended.

Form 3972 (Rev 8/12)

State Registrar 8444669

County Registrar 4/26/23

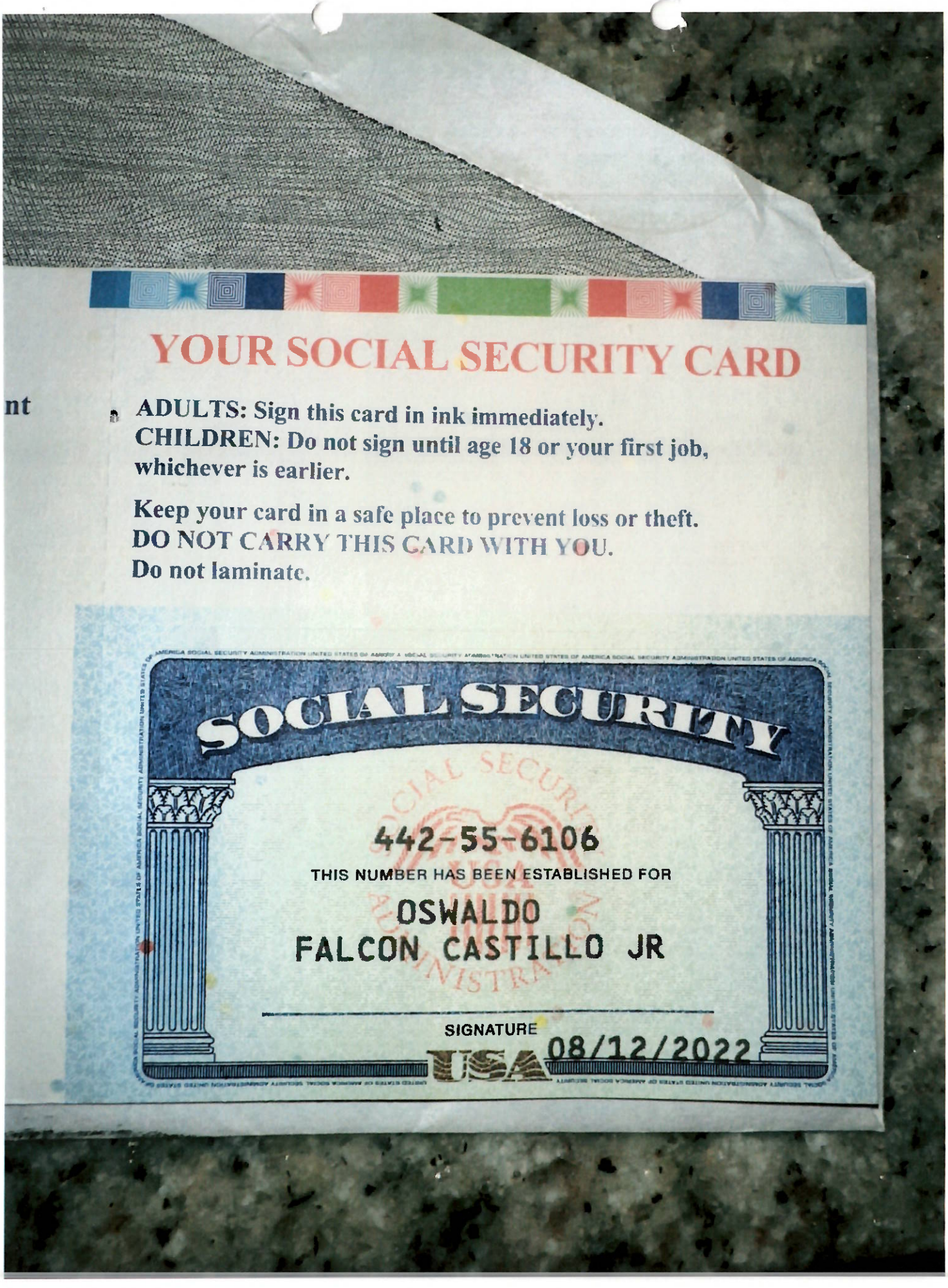
STATE OFFICE GA VITAL RECORDS

C6674611

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

STATE OF GEORGIA 1776

VOID IF ALTERED OR COPIED



YOUR SOCIAL SECURITY CARD

nt

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.

SOCIAL SECURITY

442-55-6106

THIS NUMBER HAS BEEN ESTABLISHED FOR

OSWALDO
FALCON CASTILLO JR

SIGNATURE

08/12/2022

USA

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

FALCON CASTILLO JR, OSWALDO
Child's Name (Last name, First name)

06 | 06 | 2022
Birthdate

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

[ ] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	08 29 22	10 07 22	12 16 22	09 29 23			4				
Polio	08 29 22	10 07 22	12 16 22				3				
Hepatitis B	07 04 22	08 29 22	10 07 22	12 16 22			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	08 29 22	10 07 22	12 16 22	09 29 23			4				
PCV (Under Age 5)	08 29 22	10 07 22	12 16 22	06 29 23			4				
Measles	06 29 23						1				
Mumps	06 29 23						1				
Rubella	06 29 23						1				
Hepatitis A (Born on/after 1/1/06)	06 29 23	06 03 24					2				
Varicella	06 29 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus							0				
HPV							0				
Influenza	12 16 22	01 19 23	09 29 23				3				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Georgia Immunization Office
2 Peachtree Street, NW
Suite: 13-276
Atlanta, GA 30303-3142
Certified under the authority of:
Sheila Lovett
Immunization Office Director

Sheila Lovett

06 | 29 | 2026
Certified by (Signature/Signature Stamp) **Date of Issue**

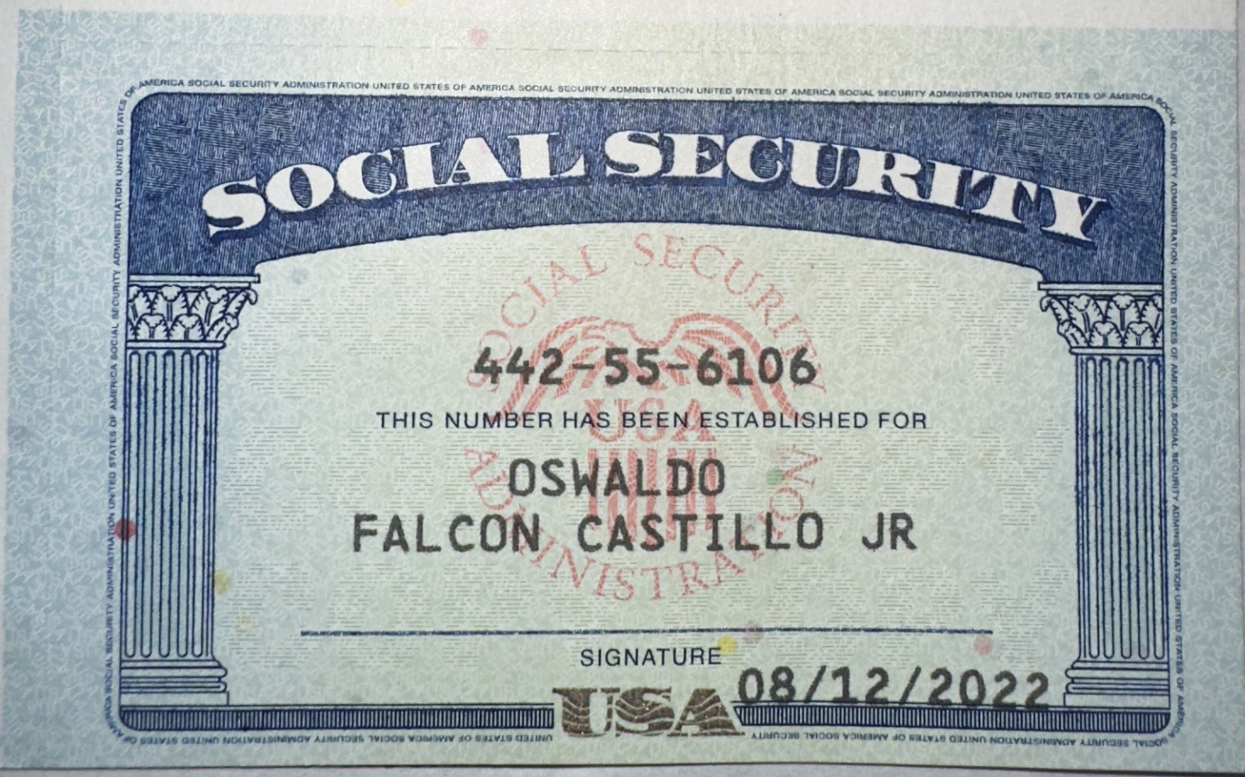
PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

YOUR SOCIAL SECURITY CARD

nt

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.



2025 W-2 and EARNINGS SUMMARY

Employee Reference Copy

W-2 Wage and Tax Statement **2025**

Copy C for employee's records. OMB No. 1545-0029

d Control number	Dept.	Corp.	Employer use only
0000002677 VF8		DRQ3	12279

c Employer's name, address, and ZIP code

KAISER FOUNDATION HEALTH PLAN OF GEORGIA INC
3495 PIEDMONT RD
ATLANTA, GA 30305

e/f Employee's name, address, and ZIP code

SHAWANNA MOLDEN
400 W PEACHTREE ST NW
UNIT 2612
ATLANTA, GA 30308

b Employer's FED ID number	a Employee's SSA number
58-1592076	XXX-XX-5439

1 Wages, tips, other comp. 51090.56	2 Federal income tax withheld
3 Social security wages 55094.63	4 Social security tax withheld 3415.87
5 Medicare wages and tips 55094.63	6 Medicare tax withheld 798.87
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12a See instructions for box 12 C 19.20
14 Other 72.37 OT PREMIUM	12b E 4004.07
	12c DD 22099.56
	12d
	13 Stat emp. / Ret. plan X / 3rd party sick pay

15 State	Employer's state ID no.	16 State wages, tips, etc.
GA	0931574-JT	51090.56

17 State income tax	18 Local wages, tips, etc.
19 Local income tax	20 Locality name

SHAWANNA MOLDEN
400 W PEACHTREE ST NW
UNIT 2612
ATLANTA, GA 30308

Social Security Number: XXX-XX-5439

© 2025 ADP, Inc.

1 Wages, tips, other comp. 51090.56 | 2 Federal income tax withheld
3 Social security wages 55094.63 | 4 Social security tax withheld 3415.87
5 Medicare wages and tips 55094.63 | 6 Medicare tax withheld 798.87
d Control number 0000002677 VF8 | Dept. | Corp. DRQ3 | Employer use only 12279
c Employer's name, address, and ZIP code: KAISER FOUNDATION HEALTH PLAN OF GEORGIA INC, 3495 PIEDMONT RD, ATLANTA, GA 30305
b Employer's FED ID number 58-1592076 | a Employee's SSA number XXX-XX-5439
7 Social security tips | 8 Allocated tips
9 | 10 Dependent care benefits
11 Nonqualified plans | 12a See instructions for box 12 C 19.20
14 Other 72.37 OT PREMIUM | 12b E 4004.07
12c DD 22099.56
12d
13 Stat emp. / Ret. plan X / 3rd party sick pay
e/f Employee's name, address and ZIP code: SHAWANNA MOLDEN, 400 W PEACHTREE ST NW, UNIT 2612, ATLANTA, GA 30308
15 State GA | Employer's state ID no. 0931574-JT | 16 State wages, tips, etc. 51090.56
17 State income tax | 18 Local wages, tips, etc.
19 Local income tax | 20 Locality name

Federal Filing Copy

W-2 Wage and Tax Statement **2025** OMB No. 1545-0029

Copy B to be filed with employee's Federal Income Tax Return.

1 Wages, tips, other comp. 51090.56 | 2 Federal income tax withheld
3 Social security wages 55094.63 | 4 Social security tax withheld 3415.87
5 Medicare wages and tips 55094.63 | 6 Medicare tax withheld 798.87
d Control number 0000002677 VF8 | Dept. | Corp. DRQ3 | Employer use only 12279
c Employer's name, address, and ZIP code: KAISER FOUNDATION HEALTH PLAN OF GEORGIA INC, 3495 PIEDMONT RD, ATLANTA, GA 30305
b Employer's FED ID number 58-1592076 | a Employee's SSA number XXX-XX-5439
7 Social security tips | 8 Allocated tips
9 | 10 Dependent care benefits
11 Nonqualified plans | 12a C 19.20
14 Other 72.37 OT PREMIUM | 12b E 4004.07
12c DD 22099.56
12d
13 Stat emp. / Ret. plan X / 3rd party sick pay
e/f Employee's name, address and ZIP code: SHAWANNA MOLDEN, 400 W PEACHTREE ST NW, UNIT 2612, ATLANTA, GA 30308
15 State GA | Employer's state ID no. 0931574-JT | 16 State wages, tips, etc. 51090.56
17 State income tax | 18 Local wages, tips, etc.
19 Local income tax | 20 Locality name

GA. State Filing Copy

W-2 Wage and Tax Statement **2025** OMB No. 1545-0029

Copy 2 to be filed with employee's State Income Tax Return.

1 Wages, tips, other comp. 51090.56 | 2 Federal income tax withheld
3 Social security wages 55094.63 | 4 Social security tax withheld 3415.87
5 Medicare wages and tips 55094.63 | 6 Medicare tax withheld 798.87
d Control number 0000002677 VF8 | Dept. | Corp. DRQ3 | Employer use only 12279
c Employer's name, address, and ZIP code: KAISER FOUNDATION HEALTH PLAN OF GEORGIA INC, 3495 PIEDMONT RD, ATLANTA, GA 30305
b Employer's FED ID number 58-1592076 | a Employee's SSA number XXX-XX-5439
7 Social security tips | 8 Allocated tips
9 | 10 Dependent care benefits
11 Nonqualified plans | 12a C 19.20
14 Other 72.37 OT PREMIUM | 12b E 4004.07
12c DD 22099.56
12d
13 Stat emp. / Ret. plan X / 3rd party sick pay
e/f Employee's name, address and ZIP code: SHAWANNA MOLDEN, 400 W PEACHTREE ST NW, UNIT 2612, ATLANTA, GA 30308
15 State GA | Employer's state ID no. 0931574-JT | 16 State wages, tips, etc. 51090.56
17 State income tax | 18 Local wages, tips, etc.
19 Local income tax | 20 Locality name

City or Local Filing Copy

W-2 Wage and Tax Statement **2025** OMB No. 1545-0029

Copy 2 to be filed with employee's City or Local Income Tax Return.

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/Guardian Name: _____ (first middle last)

Child's Name: Oswaldo Falcon-Castillo (first middle last)

Gender: ☒ Male ☐ Female

Parent/Guardian Contact Information
Daytime phone number: _____
Evening phone number: _____
Cell phone number: _____

Date of Birth: 6/6/2022

Child's Home Address: 400 W Peachtree St Nw
Unit 2612
Atlanta GA 30308-3554

VISION	HEARING	DENTAL	NUTRITION
☐ Unable to screen (explain why below) ☐ Uses corrective lenses ☐ Worn for testing	☐ Unable to screen (explain why below) ☐ Uses hearing aid / assistive device	☐ Unable to screen (explain why below)	☐ Unable to screen (explain why below)
☒ 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)	☒ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB ☐ Needs further evaluation ☐ Under professional care (explain below)	☐ Normal appearance ☐ Needs further evaluation ☐ Emergency problem observed ☐ Under professional care (explain below)	Height: 97 cm (38.19") Weight: 15.6 kg (34 lb 7 oz) BMI: 16.60 BMI%: 80% ☒ 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 ☐ Optometrist ☐ "Prevent Blindness Georgia" employee ☐ School Registered Nurse	**Screening completed by:** ☒ Physician ☐ Local Health Department ☐ Audiologist ☐ Speech-Language Pathologist ☐ School Registered Nurse	**Screening completed by:** ☐ Physician ☐ Dentist ☐ Local Health Department Registered Nurse ☐ Registered Dental Hygienist ☐ School Registered Nurse	**Screening completed by:** ☒ Physician ☐ Local Health Department ☐ Registered Dietician ☐ School Registered Nurse
Screener's Signature 9/21/26 Date *I certify that this child has received the above screening.* **Contact Information:** 2525 CUMBERLAND PKWY ATLANTA GA 30339 Dept: 404-365-0966	**Screener's Signature** 9/21/26 **Date** *I certify that this child has received the above screening.* **Contact Information:** 2525 CUMBERLAND PKWY ATLANTA GA 30339 Dept: 404-365-0966	**Screener's Signature** 9/21/26 **Date** *I certify that this child has received the above screening.* **Contact Information:** 2525 CUMBERLAND PKWY ATLANTA GA 30339 Dept: 404-365-0966	**Screener's Signature** 9/21/26 **Date** *I certify that this child has received the above screening.* **Contact Information:** 2525 CUMBERLAND PKWY ATLANTA GA 30339 Dept: 404-365-0966

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:

DPH Form 3300 Rev.2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Farley, Kinsley Brooke	**State Student ID:** 2639900
Date of Birth: 10/03/21	**Classroom:** Room 7
Parent / Guardian: Tawana Parker	**Contact Phone:** 470-903-0196

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (7 PENDING)
Remaining items needed for 100% compliance: **Child Certified Birth Certificate; Proof of GA Residency; Child Physical SSN Card; Form 3231 (Immunization Certificate); Form 3300 (Screening Certificate); Parent Photo ID; Signed Appendix D Roster Form**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Farley_Kinsley_Brooke.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Kinsley_Farley.pdf	1	✓ SIGNED
3	**CACFP IES Enrollment**	IES_form_2025_2026_Summit_-_Template_-_Template (11).pdf	11	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2639900
Student Name: Farley, Kinsley Brooke	**Date of Birth:** 10/03/21
Parent(s)/Guardian: Tawana Parker	**Phone:** 470-903-0196

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
[ACTION NEEDED]	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
[ACTION NEEDED]	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
[ACTION NEEDED]	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
[ACTION NEEDED]	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2639900
Scan the QR code or click the link above. Use child's Date of Birth (**10/03/21**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Farley, Kinsley Brooke** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Kinsley
Name Suffix (Jr,II,III):
Legal Middle Name: Brooke
Name Child is Called:
Legal Last Name: Farley
Child's Social Security #: ___-___-___ Pending (30-Day Waiver) 10/03/2021
Gender: M [ ] F [X]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/24/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Parker
First Name: Tawana
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: tparker23411109230939@gmail.com
Zip Code: 30315

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

2026-07-31

Parent/Guardian Signature **Date**

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note:** Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Fairley Kinsley	SNAP	☑	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

Child Income/How often? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Kinsley Fairley	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. Tawana Parker	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. First Name Last Name	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5.	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX 0970 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday ☑ Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday Saturday

Circle the meals your child will normally receive while in care: ☑ Breakfast AM Snack ☑ Lunch ☑ PM Snack Supper Evening Snack

PART IV: Signature
*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care.* ***If not completed fully and signed, the participant will be placed in the Paid category.***

Tawana Parker

Signature: X _____ **Print Name:** Tawana Parker **Date:** 2026-07-13

Address: 55 Milton Ave Se **City:** Atlanta **State:** _____ **Zip:** 30315 **Phone:** 4709030196

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: Total Income **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** House Hol

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility:** check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: Tawana Parker **Date:** Select date

Confirming Official's Signature: _____ **Date:** Select date

Follow Up Official's Signature: _____ **Date:** Select date

12/2022

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits on the Annual Income Eligibility Guidelines.

Household Size	Yearly Income
1	**Please refer to the Income Eligibility Guidelines that are updated annually and available at** **https://www.decal.ga.gov/documents/attachments/Incomeeligibguidelines.pdf**
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: 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 your child for free or reduced-price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

12/2022

Sources of Income Chart[1]

INSTRUCTIONS

Households that receive SNAP, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a SNAP, TANF, or FDPIR case number. For adult day care, list participant's name and a SNAP, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children. Note:** Children in Foster care, enrolled in Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Please refer to the Q&A section for a definition of each free categorical eligibility.
Part II: Skip this part.
Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.
Part II: To report total household income from last month, complete the following:
A- Child Income: Please indicate the TOTAL income received by **Child** household members listed in PART I. Please list any child income and how often it is received in this section.
B – Adult Income: List the first and last name of each **Adult** person living in your household as an economic unit. You must indicate yourself and all other adult members living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant should be listed here as well. Attach another sheet if necessary.
List Gross Income. Next to each person's name, list each type of income received last month, and how often it was received.
B-Column 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
B-Column 2: List the amount each person got last month from welfare, child support, alimony.
B-Column 3: List Social Security, pensions, and retirement.
B-Column 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Social Security Number: If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or mark the "I don't have a Social Security Number" box.
If no income: If the person does not receive income from any source, write "0". If "0" is entered or any income fields are blank, the person is certifying that there is no income to report. Please note that the last four digits of his or her Social Security Number is REQUIRED when/if **Part II B** is completed and household members are listed (with or without income).

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

C – Total Household Members. Please list the total number of all household members (children and adults) in this section.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must complete this section completely and then sign the form. Please refer back to Part II to ensure the last four digits of his/her social security number have been recorded or the box has been marked if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

o

The Child and Adult Care Food Program

Income Eligibility Statement Form and Supporting Documents

The United States Department of Agriculture (USDA) issued revised Income Eligibility Statements (IES) and other required forms to all state agencies to disseminate to institutions participating in the Child and Adult Care Food Program (CACFP). The newly revised IES package includes the following: IES form and instructions, reduced income guidelines template with privacy and non-discrimination statement, Sharing Information with Medicaid/SCHIP letter, sample house-hold letters based on program type, and template letters to use when verifying income and reporting the results of the verification. This newly revised IES application conforms to USDA's newly released prototypes and therefore meet all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

The revised IES package and supporting documents is available at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

Frequently Asked Questions

Q. What information do I issue to parents?

A. Institutions and facilities should issue the (1) IES form, reduced income guidelines with the privacy and non-discrimination statement, (2) appropriate household letter, and the (3) Sharing Information with Medicaid/SCHIP letter to parents/guardians of children/adults participating in the CACFP.

Q. Can centers/day care homes require parents/guardians to complete the IES form as part of the enrollment package?

A. Centers/day care homes can **request** that parents/guardians complete the form as part of the enrollment process, but centers should **not require** parents/guardians to complete the form nor should they have policies/practices in place that negatively impacts the prospective/current participant's enrollment if the parent declines or fails to complete or submit the form. This action would be in violation of the Program.

Q. If the parent, guardian, or adult member completing the form does not specify income but lists household members in Part II B, are the last four digits of the social security number required?

A. Yes, when a free or reduced eligibility determination is based upon Part II, whether income is specified or not specified, the last four digits of the social security number is required. As per the Privacy Act Statement, the information provided is used to determine if the child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs.

Q. Why is it necessary to issue the Sharing Information with Medicaid/SCHIP letter to parents?

A. Parents/guardians that do not wish to have their information shared with either Medicaid or SCHIP must complete the form and return to facility. Otherwise and when requested by Bright from the Start or the United States Department of Agriculture (USDA), parent/guardian information will be shared with Medicaid/SCHIP.

Q. Is it necessary to have three official's signatures on the new IES form-especially when the center is an independent center with only one staff person managing the CACFP?

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

A. No. Only one signature is required for Independent centers with only one staff person responsible for managing the CACFP. However, institutions with more than one person managing the CACFP, and center and administrative sponsors are required to have a minimum of two signatures: **determining official and confirming official**.

Q. What is the purpose of having a determining and confirming official signature?

A. The confirming official will review the form and ensure accuracy and completeness. IES forms are considered current and valid until the last day of the month in which the form was dated on year earlier. The date to be used to make this determination is the date in which the sponsor or institution official signs the IES form to certify eligibility of the participant.

Q. How long is the IES form considered current and valid?

A. IES forms are considered current and valid until the last day of the month in which the form was dated one year previously. The date used to make this determination is the date in which the sponsor/ independent center official or parent/guardian signs the IES form. CACFP institutions and SFSP sponsors must decide which date they will use as the effective date and apply this date to all income eligibility forms submitted on behalf of all participants. CACFP institutions and SFSP sponsors are required to complete the **Income Eligibility - Effective Date Option Form.** In addition, institutions must indicate the options chosen in Section VIII. Recordkeeping (Item #2) of their Management Plan.

This means that sponsor and independent center officials should not request parent/guardians to complete IES forms at a specific frequency (e.g. start of each school year, every June, etc.). Request made by the sponsor or independent center official for IES form completion should be based solely on the expiration date of the IES forms.

Q. Do I send a report to Bright from the Start listing parent/guardians that want their information shared with Medicaid/SCHIP?

A. No. When instructed by USDA, Bright from the Start will request and collect data from institutions.

Q. Can this form be used for children in childcare facilities and adults in adult daycare facilities?

A. Yes.

Q. Can siblings be listed on one form?

A. Yes. Siblings from the same household can be listed on one form as long as there is space available.

Q. When do I verify parent/guardian income?

A. At the request of the United States Department of Agriculture (USDA), Bright from the Start, or any of its agents.

Q. Where can I get copies of the IES form and supporting documents?

A. Access Bright from the Start's webpage at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

Q. Can I still participate in the CACFP if parents do not complete the IES form or do not return the form to my center?

A. Yes. However, children that do not have IES forms on file must be placed in the "**paid**" category on the roster, which will effect monthly reimbursement. Centers that are using the IES form to capture annual enrollment information will be required to use an alternate enrollment form that captures at a

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

minimum the name of the child, normal hours and days of care and meals the child usually receives while in attendance.

Q. What if the form is completed by the parent but is not signed and dated by the sponsor or independent official. Is the form valid?

A. The form would neither be current nor valid for free or reduced price meals since the signature and date of the sponsor or independent official is the certification of the eligibility of the participant.

Q. Are households required to report changes in circumstances?

A. No, Public Law 108-265 modified the requirements related to reporting changes in income during the period of eligibility covered by the application. Households are not required to report changes in circumstances, such as increase in income, a decrease in household size, or when the household is no longer certified eligible for benefits through Supplemental Nutrition Assistance Programs (SNAP) or Temporary Assistance for Needy Families (TANF).

Q. Are temporary approvals (45 days) still required when no income is reported?

A. No. Temporary approvals previously provided for short term assistance, such as when a household experienced a temporary income reduction or when no income was reported have been eliminated, are no longer required. Now, year-long eligibility includes households that report no income on their IES forms.

Q. Can parents list some but not all of the household income received?

A. No, the IES form requests all the household income including the frequency. By signing the IES form the parent/guardian certifies that all the information on the form is true and that all income is reported and that they understand that the center or day care home will receive Federal funds based on the information listed by the parent/guardian.

Q. Do children participating in Head Start or Early Head Start need to complete additional income eligibility forms to qualify for free meals?

A. Children enrolled in federal and state-funded Head Start or Early Head Start Programs are categorically eligible to receive free meal benefits without further application or eligibility determination. Categorical eligibility means Meal Benefit Forms are not required.

Eligibility determinations for the CNPs are made on an annual basis. As long as the child is enrolled in Head Start or Early Head Start at the time the annual eligibility determination is made, all reimbursable meals served to that child may be claimed at the free rate.

Institutions, sponsors, and school food authorities may establish eligibility of all Head Start enrollees through documentation provided by the Head Start program. Forms of acceptable documentation include:

- Approved Head Start application
- Statement of Head Start enrollment
- List of participants from a Head Start official

Q. If a child who is eligible for Head Start benefits also attends a child care center or day care home, is the child automatically eligible for free CACFP meals at the child care facility without further application or eligibility determination?

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

A. Yes. All CACFP reimbursable meals served to children enrolled in Head Start or Early Head Start may be claimed at the free rate by child care centers or at Tier I rates in day care homes in which they are enrolled. Documentation of acceptable Head Start eligibility must be maintained.

Q. Are the siblings or other children who are members of a Head Start child's household also automatically eligible for free meals without further application?

A. Only children enrolled in Head Start are categorically eligible. Categorical eligibility based on Head Start enrollment does not extend to all children in the same household.

Q. Can a day care home document its eligibility for Tier I reimbursement based on the provider's own child's enrollment in a Head Start program?

A. The Improving Head Start for School Readiness Act of 2007 (Public Law 110-134) extended categorical eligibility only to children enrolled in Head Start; therefore, a child's Head Start enrollment does not extend to the provider.

Q. Are children who are enrolled in Head Start, but who are members of households that are above the Head Start income eligibility requirements, still eligible for CACFP meals at the free rate?

A. Yes. All reimbursable meals served to children enrolled in Head Start may be claimed at the free rate. Head Start serves primarily children from families with household incomes at or below the federal poverty level. However, a small proportion of children in families with household incomes above the poverty level may also be served.

Public Law 110-134 amended sections 9(b)(12)(A)(iii) and 17(c)(5) of the Richard B. Russell National School Lunch Act to make any child enrolled in Head Start categorically eligible for free meals without further application or eligibility determination.

Q. Are children enrolled in state-funded prekindergarten programs eligible for free meals?

A. Children participating in state-funded prekindergarten programs are not automatically eligible for free meals. In California, the income eligibility requirements for state-funded preschools are less stringent than the requirements for the Head Start Program. Therefore, determinations of eligibility for free meals for participants must be made on an individual basis.

Section 107 of the Child Nutrition and WIC Reauthorization Act of 2004 (Act) amended section 9(b) of the Richard B. Russell National School Lunch Act to make runaway, homeless and migrant children categorically eligible for free meal benefits under the National School Lunch and School Breakfast Programs and is effective July 1, 2004.

Q. What is the definition of homeless?

A. The term "homeless children" has the meaning given to "homeless children and youths" in section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)).

"Homeless children" means:

1. Individuals who lack a fixed, regular, and adequate nighttime residence; and

2. Includes -

    a. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; are

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

b. Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

c. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

d. Migratory children who qualify as homeless because they are living in circumstances described in a-c above.

Q. What is the definition of migrant?

A. Migrant family means, for purposes of CACFP eligibility, a family with children under the age of compulsory school attendance who changed their residence by moving from one geographic location to another, either intrastate or interstate, within the preceding two years for the purpose of engaging in agricultural work and whose family income comes primarily from this activity.

Q. What is the definition of runaway youth?

A. The term "runaway", used with respect to a youth, means an individual who is less than 18 years of age and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian. https://definitions.uslegal.com/r/runaway-youth

Q. What is the definition of Foster care?

A. Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child-care institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the state or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is federal matching of any payments that are made.

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.* Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced-price meals.).

□ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address:_____

For more information, you may call _____ at _____

CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHIP.

Document Ref: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

Signature Certificate

Reference number: 9ABAE8AA-EA10-4016-B1AC-7C19EB4B86F1

Sent on **September 14, 2026 9:57 PM UTC**

Signed By	Signature
Tawana Parker tparker23411109230939@gmail.com Viewed: September 14, 2026 9:57 PM UTC Signed: September 14, 2026 10:03 PM UTC	 IP address: 2603:3001:538:c100:cdf9:13ab:2b52:239f Location: Atlanta, US

Document completed by all parties on
September 14, 2026 10:03 PM UTC

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Hall, Ellaina Christine	**State Student ID:** 2609511
Date of Birth: 08/29/22	**Classroom:** Room 7
Parent / Guardian: Danielle Willis-Hall & Brodrick Hall	**Contact Phone:** 770-255-9486 / 770-680-8545

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (2 PENDING)
Remaining items needed for 100% compliance: **Child Physical SSN Card; Form 3300 (Screening Certificate)**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Hall_Ellaina_Christina.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_7083c6.pdf	9	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Date: September 15, 2026	**Classroom:** Room 7 (Site ID: 33915)
Student Name: Hall, Ellaina Christina	**Date of Birth:** 08/29/2022
Parent(s)/Guardian: Danielle Willis-Hall & Fredrick Hall	**Phone:** 404-918-3561

Dear Parent/Guardian,

Under **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all students attending Georgia's Pre-K Program must have complete, state-mandated documentation on file at the center. During our compliance and data collection audit, the documentation below was identified as missing or incomplete for your child.

ACTION REQUIRED — OUTSTANDING ITEMS NEEDED:

- **Child Physical SSN Card (30-day waiver active)**
- **Form 3300 (Ear, Eye, Dental Screening)**

Important Guidelines for Required Documents:

- **Form 3300 (Screening):** Must include all four components (Ear/Hearing, Eye/Vision, Dental, and Nutrition). Blood pressure and lead screening must be recorded.
- **Form 3231 (Immunizations):** Must be a current Georgia Certificate of Immunization with valid expiration date or marked 'Complete for School'.
- **Proof of Residence:** Current gas, electric, or water utility bill (dated within 30 days) or valid lease agreement showing matching home address.
- **Social Security / 30-Day Waiver:** If an official 30-day waiver was signed, the physical card or proof of card order from SSA must be presented before the grace period expires.

COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please submit clear, readable copies immediately to ensure your child's enrollment remains in active standing with Georgia DECAL.

- **Email Submissions:** Send scanned copies or clear photos directly to **Ms. Karen Harris** at: karenharris@kidazzle.com
- **In-Person Submissions:** Hand-deliver original documents or copies to the Administrative Front Desk.
- **Questions / Support:** Call Ms. Harris at **(404) 753-8884** or mobile at **(404) 884-1483**.

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Hall, Ellaina Christina** Parent Signature: _____ Date: _____

BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box → 2026-2027

Pre-K Registration Form
School Year

PROVIDER LEGAL NAME: (This section to be completed by the provider)

SCHOOL/SITE NAME: KIDAZZLE- Summit

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)	
CHILD'S LAST NAME: HALL	
CHILD'S FIRST NAME: ELLIANA	
CHILD'S MIDDLE NAME: CHRISTINE	NAME SUFFIX: (i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY): 08/29/2022 SEX: [ ]M [✓]F
HOME ADDRESS (*Do not enter PO Box Info*): 128 Hillside Ave SE	COUNTY: Fulton
CITY: Atlanta STATE: GA ZIP: 30315	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: Hall	FIRST: Danielle	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: (770) 255 9486	
Email Address: danielle.willis@icloud.com		
Place of Employment: AmericasMart	Work Phone: (404) 220 2140	
Address: 240 Peachtree St NW, Suite 2200		
City: Atlanta State: GA	Zip: 30303	
Parent/Guardian #2 - LAST NAME: Hall	FIRST: Bredrick	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: (770) 680 8345	
Email Address: Healthcare IT Contractor		
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. Christopher Willis	uncle	404 740 1779		
2. Gabrielle Johnson	aunt	470 216 4969		

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: Danielle Hall **DATE:** 2/13/2026

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. Gabrielle Johnson		aunt	470 216 4969
2. Viria Johnson		maternal grand mother	404 839 3884
3. Christopher Willis		uncle	404 740 1779
4. Joyce Hall		paternal grandmother	912 655 3520

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Intown Pediatrics

DATE OF LAST FULL HEALTH SCREENING: 1/28/2024 PHONE: (404) 446 4726

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

not applicable

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

not applicable

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:

not applicable

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): Danielle Hall

DATE: 2/13/2026

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, Ellaina Hall, 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: KIDazzle Child Care

SIGNATURE (Parent/Guardian): Danielle Hall

DATE: 2/13/2026

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1. KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning August 1, 2024 (date) and continuing until written notification is provided by either party. The operating hours are ~~6:30~~ 7:00 am – ~~6:00~~ 5:30 pm, Monday – Friday.

Ellaina Hall
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: Pre K Program Pay: 0 Sponsor Pay: 100 Reg. Fee: $50.00
Total Weekly Tuition: 100

I understand that I am responsible for $ 100 per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast **Lunch** **Afternoon Snack** **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: Danielle Hall

Date: 2/13/2020

Facility Administrator Signature: K. Hans

Date: 8/13/20

Georgia Dept of Early Care and Learning
RIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): ___/___/___		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security # ___-___-___	DOB (M/D/Y): ___/___/___	Gender: M ☐ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): ___/___/___	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	Other ☐
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☐ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☐ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☐ **No**

_____ _____

Parent/Guardian Signature **Date**

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: Danielle Hall **Date:** 2/13/2026

Administrative Signature: K. Harris **Date:** 8/13/24

Teacher Signature: _____ **Date:** _____

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

HALL, ELLAINA CHRISTINE
Child's Name (Last name, First name)

08 | 29 | 2022
Birthdate

HALL, DANIELLE NICOLE
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

( ) (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

( ) (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

( ) (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	10 31 22	01 04 23	03 02 23	11 30 23			4				
Polio	10 31 22	01 04 23	03 02 23	11 30 23			4				
Hepatitis B	08 29 22	10 31 22	01 04 23	03 02 23			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	10 31 22	01 04 23	03 02 23	11 30 23			4				
PCV (Under Age 5)	10 31 22	01 04 23	03 02 23	08 31 23			4				
Measles	08 31 23						1				
Mumps	08 31 23						1				
Rubella	08 31 23						1				
Hepatitis A (Born on/after 1/1/06)	08 31 23	03 07 24					2				
Varicella	11 30 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus	10 31 22	01 04 23	03 02 23				3				
HPV							0				
Influenza	09 30 24	01 28 26					2				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Chyna Taylor MD
490 Bill Kennedy Way SE
Atlanta, GA 30316

C. Taylor 01/28/26

Certified by (Signature/Signature Stamp) **Date of Issue**

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME: Elliana Hall SEX: F BIRTHDATE: 8.29.22

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No ___ Unknown ___ Yes ✓ (1mo)
   - Fluoridated water? No ___ Unknown ___ Yes ✓ (daily)
   - Fluoride Supplement diet? (tablets ___, liquid ___) No ✓ Unknown ___ Yes ___

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?
   No

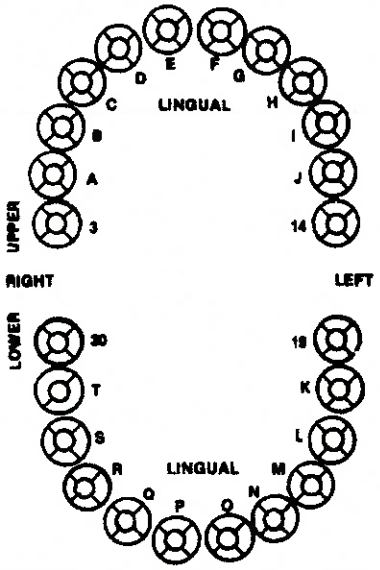
PART I. TO BE COMPLETED BY HEAD START STAFF

3. CHILD (✓ HAS, ___ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name Dr. Minh Annie Date last visit 02/10/2026
4. CHILD (✓ IS, ___ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name Freddy Batraille
5. CHILD (___ IS, ✓ IS NOT) RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	✓	Liver Dis.	___	✓
Asthma	___	✓	Rheumatic Fever	___	✓
Bleeding	___	✓	Sickle Cell Dis.	___	✓
Diabetes	___	✓	Other (List Below)	___	✓
Epilepsy	___	✓			
Heart/Vascular Dis.	___	✓			

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider _____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party) _____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊘), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☑ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☒ E. NO PROBLEMS

   Approximate number of visits 2x yr. Approximate cost _____

   completed on 02/10/2026 Routine follow up in 6mo scheduled.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (✓ is, ___ is not) complete. If not, explain here, as well as items checked.

   _____

   _____

   - ☑ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature _____ Date 02/10/2026

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

INTERVIEWER: GO TO FORM 6

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Hood, Michelle Gwendolyn	**State Student ID:** 2609493
Date of Birth: 07/23/22	**Classroom:** Room 7
Parent / Guardian: Nashallie D. (Meshalle) & Derrick T. Hood	**Contact Phone:** 404-747-1902

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Hood_Michelle_G.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_028dbf.pdf	32	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	CamScanner 09-23-2026 15.53.pdf	1	✓ VERIFIED
4	**Proof of Georgia Residency**	Solid Waste Bill.pdf	1	✓ VERIFIED
5	**Head Start Physical Exam (Form #78)**	CamScanner 10-26-2026 15.54.pdf	2	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Date: September 15, 2026	**Classroom:** Room 7 (Site ID: 33915)
Student Name: Hood, Michelle G.	**Date of Birth:** 07/23/2022
Parent(s)/Guardian: Nashallie D. (Meshalle) & Derrick T. Hood	**Phone:** 404-747-1902

Dear Parent/Guardian,

Under **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all students attending Georgia's Pre-K Program must have complete, state-mandated documentation on file at the center. During our compliance and data collection audit, the documentation below was identified as missing or incomplete for your child.

ACTION REQUIRED — OUTSTANDING ITEMS NEEDED:

- **Form 3300 (Ear, Eye, Dental Screening)**
- **Current Proof of Residency (Utility Bill within 30 days)**

Important Guidelines for Required Documents:

- **Form 3300 (Screening):** Must include all four components (Ear/Hearing, Eye/Vision, Dental, and Nutrition). Blood pressure and lead screening must be recorded.
- **Form 3231 (Immunizations):** Must be a current Georgia Certificate of Immunization with valid expiration date or marked 'Complete for School'.
- **Proof of Residence:** Current gas, electric, or water utility bill (dated within 30 days) or valid lease agreement showing matching home address.
- **Social Security / 30-Day Waiver:** If an official 30-day waiver was signed, the physical card or proof of card order from SSA must be presented before the grace period expires.

COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please submit clear, readable copies immediately to ensure your child's enrollment remains in active standing with Georgia DECAL.

- **Email Submissions:** Send scanned copies or clear photos directly to **Ms. Karen Harris** at: karenharris@kidazzle.com
- **In-Person Submissions:** Hand-deliver original documents or copies to the Administrative Front Desk.
- **Questions / Support:** Call Ms. Harris at **(404) 753-8884** or mobile at **(404) 884-1483**.

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Hood, Michelle G.** Parent Signature: _____ Date: _____

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box → 2026-27

Pre-K Registration Form School Year

PROVIDER LEGAL NAME: (This section to be completed by the provider)

SCHOOL/SITE NAME: KIDazzle - Summit

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)			
CHILD'S LAST NAME: HOOD			
CHILD'S FIRST NAME: MICHELLE			
CHILD'S MIDDLE NAME: GWENDOLYN	NAME SUFFIX:		(i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#: 828 64 4710	D.O.B. (MM/DD/BY): 07/23/2022	SEX: [ ]M [X]F	
HOME ADDRESS (*Do not enter PO Box Info*): 7182 Walton Hl	COUNTY: Fulton		
CITY: Fairburn	STATE: GA	ZIP: 30213	HOME PHONE: (404) 484-3924

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: Hood (Nelson)	FIRST: NaShalle	MIDDLE INITIAL: D	
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: (404) 484-3924	Cell Phone: (404) 484-3924		
Email Address: ndnelsonhood@gmail.com			
Place of Employment: City of Atlanta Police Department	Work Phone: (404) 977-3397		
Address: 226 Peachtree St SW			
City: Atlanta	State: Ga	Zip: 30303	
Parent/Guardian #2 - LAST NAME: Hood	FIRST: Derrick	MIDDLE INITIAL: T	
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: (404) 914-0972	Cell Phone: (404) 914-0972		
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. Mary Nelson	Grandmother	404-453-1693		mfnelson65@gmail.com
2. Tangela Ross	Aunt	404-429-8112		tangelamross@gmail.com

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:** 01/15/2026

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):

*Allergic to cow's milk

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

N/A

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:

N/A

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): Michelle Hood

DATE: 01/15/2026

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, Michelle G. Hood, 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: KiDazzle Summit - 401 W. Peachtree St.

SIGNATURE (Parent/Guardian): Michelle Hood

DATE: 01/15/2026

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning _____ (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Michelle G. Hood
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast **Lunch** **Afternoon Snack** **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: _____

Date: 01/15/2026

Facility Administrator Signature: _____

Date: 8/3/24

Georgia Dept of Early Care and Learning
RIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 01/15/2026

CHILD INFORMATION:

Legal First Name: Michelle
Name Suffix (Jr,II,III):
Legal Middle Name: Gwendolyn
Name Child is Called: Michii (Meechy)
Legal Last Name: Hood
Child's Social Security # 828-64-4710
DOB (M/D/Y): 07/23/2021
Gender: M ☐ F ☑
Choose Not to Provide SSN ☐
Date enrolled in Pre-K (M/D/Y): / /

PARENT/GUARDIAN INFORMATION:

Last Name: Hood
First Name: NaShalle
Relationship: Mother ☑ Father ☐ Grandparent ☐ Guardian ☐ Other ☐
Email Address: ndnelsonhood@gmail.com
Zip Code: 30213

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

Parent/Guardian Signature — **Date** 01/15/2026

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

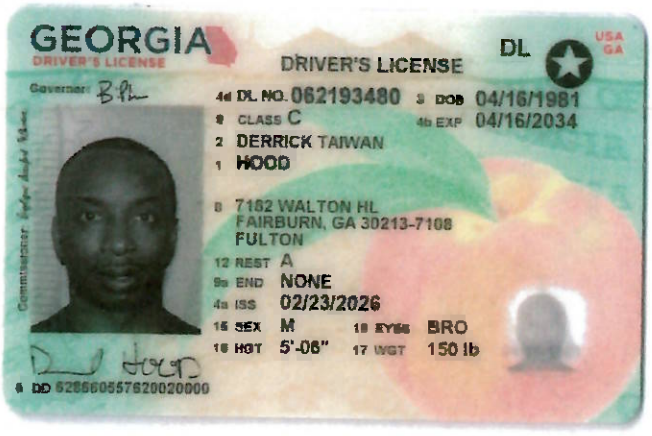
- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 01/15/2026

Administrative Signature: _____ **Date:** 8/13/24

Teacher Signature: _____ **Date:** _____


GEORGIA
DRIVER'S LICENSE
DRIVER'S LICENSE
DL
USA
GA
Governor:
4d DL NO. 062193480
3 DOB 04/16/1981
9 CLASS C
4b EXP 04/16/2034
2 DERRICK TAIWAN
1 HOOD
8 7162 WALTON HL
FAIRBURN, GA 30213-7108
FULTON
12 REST A
9a END NONE
4a ISS 02/23/2026
15 SEX M
18 EYES BRO
16 HGT 5'-06"
17 WGT 150 lb
Commissioner
5 DD 62656055762002000


GEORGIA
DRIVER'S LICENSE
DRIVER'S LICENSE
DL
USA
GA
Governor
Commissioner
4d DL NO. 049626901
3 DOB 07/07/1983
8 CLASS C
4b EXP 07/07/2027
2 NASHALLE NELSON
1 HOOD
5 7182 WALTON HL
FAIRBURN, GA 30213
FULTON
12 REST A
9a END NONE
4a ISS 07/05/2019
15 SEX F
18 EYES BRO
16 HGT 5'-03"
17 WGT 210 lb
DD 386161380160033200

W2 & EARNINGS SUMMARY

PARAGON SYSTEMS, INC
4330 PARK TERRACE DRIVE
WESTLAKE VILLAGE, CA 91361

DERRICK HOOD

	Filing Status	Exemptions
FITWH	H	$100
GA	H	0 + $20

OTHER

Description	Amount	Box
OTPremium	1107.89	14

WAGES

TOTAL GROSS WAGES	72104.12

Description	Amount	Box
Fed. Taxable Wages	72104.12	1
Soc. Security Wages	72104.12	3
Medicare Wages	72104.12	5
GA Taxable Wages	72104.12	16

WITHHOLDINGS

Description	Amount	Box
Fed. Income Tax	8207.50	2
Soc. Security Tax	4470.48	4
Medicare Tax	1045.53	6
GA Income Tax	3373.57	17

FOLD AND DETACH

a Employee's social security number ***-**-2399

c Employer's name, address, and ZIP code
PARAGON SYSTEMS, INC
4330 PARK TERRACE DRIVE
WESTLAKE VILLAGE, CA 91361

b Employer's identification number: 63-0937443
d Control Number: 162314-865413

e Employee's name and address
DERRICK HOOD
7182 WALTON HILL
FAIRBURN, GA 30213

1 Wages,tips,other compensation	2 Federal income tax
72104.12	8207.50
3 Social security wages	4 Social security tax
72104.12	4470.48
5 Medicare wages and tips	6 Medicare tax withheld
72104.12	1045.53
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12 See instrs. for box 12
13 Stat emp. Ret. Plan 3 Party Sick: X	
14 Other: OTPREMI 1107.89	

15 State & Employer's state ID	16 State wages,tips,etc	17 State income tax	18 Local wages,tips,etc.	19 Local income tax	20 Locality name
GA 2111533-YF	72104.12	3373.57			

W2 Wage and Tax Statement 2025 — Federal Filing Copy

a Employee's social security number ***-**-2399

c Employer's name, address, and ZIP code
PARAGON SYSTEMS, INC
4330 PARK TERRACE DRIVE
WESTLAKE VILLAGE, CA 91361

b Employer's identification number: 63-0937443
d Control Number: 162314-865413

e Employee's name and address
DERRICK HOOD
7182 WALTON HILL
FAIRBURN, GA 30213

1 Wages,tips,other compensation: 72104.12
2 Federal income tax: 8207.50
3 Social security wages: 72104.12
4 Social security tax: 4470.48
5 Medicare wages and tips: 72104.12
6 Medicare tax withheld: 1045.53
7 Social security tips:
8 Allocated tips:
9:
10 Dependent care benefits:
11 Nonqualified plans:
12 See instrs. for box 12:
13 Stat emp. Ret. Plan 3 Party Sick: X
14 Other: OTPREMI 1107.89

15 State & Employer's state ID: GA 2111533-YF
16 State wages,tips,etc: 72104.12
17 State income tax: 3373.57
18 Local wages,tips,etc.:
19 Local income tax:
20 Locality name:

W2 Wage and Tax Statement 2025 — State Filing Copy

a Employee's social security number ***-**-2399

c Employer's name, address, and ZIP code
PARAGON SYSTEMS, INC
4330 PARK TERRACE DRIVE
WESTLAKE VILLAGE, CA 91361

b Employer's identification number: 63-0937443
d Control Number: 162314-865413

e Employee's name and address
DERRICK HOOD
7182 WALTON HILL
FAIRBURN, GA 30213

1 Wages,tips,other compensation: 72104.12
2 Federal income tax: 8207.50
3 Social security wages: 72104.12
4 Social security tax: 4470.48
5 Medicare wages and tips: 72104.12
6 Medicare tax withheld: 1045.53
7 Social security tips:
8 Allocated tips:
9:
10 Dependent care benefits:
11 Nonqualified plans:
12 See instrs. for box 12:
13 Stat emp. Ret. Plan 3 Party Sick: X
14 Other: OTPREMI 1107.89

15 State & Employer's state ID: GA 2111533-YF
16 State wages,tips,etc: 72104.12
17 State income tax: 3373.57
18 Local wages,tips,etc.:
19 Local income tax:
20 Locality name:

W2 Wage and Tax Statement 2025 — City or Local Filing Copy

a Employee's social security number ***-**-2399

c Employer's name, address, and ZIP code
PARAGON SYSTEMS, INC
4330 PARK TERRACE DRIVE
WESTLAKE VILLAGE, CA 91361

b Employer's identification number: 63-0937443
d Control Number: 162314-865413

e Employee's name and address
DERRICK HOOD
7182 WALTON HILL
FAIRBURN, GA 30213

1 Wages,tips,other compensation: 72104.12
2 Federal income tax: 8207.50
3 Social security wages: 72104.12
4 Social security tax: 4470.48
5 Medicare wages and tips: 72104.12
6 Medicare tax withheld: 1045.53
7 Social security tips:
8 Allocated tips:
9:
10 Dependent care benefits:
11 Nonqualified plans:
12 See instrs. for box 12:
13 Stat emp. Ret. Plan 3 Party Sick: X
14 Other: OTPREMI 1107.89

15 State & Employer's state ID: GA 2111533-YF
16 State wages,tips,etc: 72104.12
17 State income tax: 3373.57
18 Local wages,tips,etc.:
19 Local income tax:
20 Locality name:

W2 Wage and Tax Statement 2025 — Employee Reference Copy

2025 W-2 and EARNINGS SUMMARY

This summary section is included with your W-2 to help describe this portion in more detail. The reverse side includes general information that you may also find helpful. The following reflects your final pay stub, plus any adjustments made by your employer.

GROSS PAY	59,555.87	SOCIAL SECURITY TAX WITHHELD BOX 04 OF W-2	0.00
FED. INCOME TAX WITHHELD BOX 02 OF W-2	3,536.14	MEDICARE TAX WITHHELD BOX 06 OF W-2	762.96
STATE INCOME TAX BOX 17 OF W-2	1,821.57	SUI/SDI BOX 14 OF W-2	0.00
LOCAL INCOME TAX BOX 19 OF W-2	0.00		

To change your employee W-4 profile information file a new W-4 with your payroll department

Social Security Number: XXX-XX-0500

NASHALLE D NELSON
7182 WALTON HILL
FAIRBURN, GA 30213

© 2025 ADP, Inc.

Fold and Detach Here

Employee Reference Copy

W-2 Wage and Tax Statement **2025**

OMB No. 1545-0029

Copy C for employee's records.

Control number	Dept.	Corp.	Employer use only
0000005139 RPZ		BJ00	E S 7876

Employer's name, address, and ZIP code

CITY OF ATLANTA
68 MITCHELL ST SW SUITE 6100
ATLANTA, GA 30303

e/f Employee's name, address, and ZIP code

NASHALLE D NELSON
7182 WALTON HILL
FAIRBURN, GA 30213

Employer's FED ID number 58-6000511	a Employee's SSA number XXX-XX-0500
Wages, tips, other comp. 46455.45	2 Federal income tax withheld 3536.14
Social security wages	4 Social security tax withheld
Medicare wages and tips 52617.77	6 Medicare tax withheld 762.96
Social security tips	8 Allocated tips
	10 Dependent care benefits
Nonqualified plans	12a See instructions for box 12 DD 20358.26
Other 5928.78 BEN INS 6162.32 PEN PLANS 1009.32 STD INS	12b
	12c
	12d
	13 Stat emp. X / Ret. plan / 3rd party sick pay
State GA / Employer's state ID no. 0432896-TH	16 State wages, tips, etc. 46455.45
State income tax 1821.57	18 Local wages, tips, etc.
Local income tax	20 Locality name

Federal Filing Copy

FOLD AND DETACH HERE

GA. State Filing Copy

W-2 Wage and Tax Statement **2025**

1 Wages, tips, other comp. 46455.45	2 Federal income tax withheld 3536.14
3 Social security wages	4 Social security tax withheld
5 Medicare wages and tips 52617.77	6 Medicare tax withheld 762.96
d Control number 0000005139 RPZ / Dept. / Corp. BJ00 / Employer use only E S 7876	
c Employer's name, address, and ZIP code: CITY OF ATLANTA 68 MITCHELL ST SW SUITE 6100 ATLANTA, GA 30303	
b Employer's FED ID number 58-6000511	a Employee's SSA number XXX-XX-0500
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12a DD 20358.26
14 Other 5928.78 BEN INS 6162.32 PEN PLANS 1009.32 STD INS	12b
	12c
	12d
	13 Stat emp. / Ret. plan X / 3rd party sick pay
e/f Employee's name, address and ZIP code: NASHALLE D NELSON 7182 WALTON HILL FAIRBURN, GA 30213	
15 State GA / Employer's state ID no. 0432896-TH	16 State wages, tips, etc. 46455.45
17 State income tax 1821.57	18 Local wages, tips, etc.
19 Local income tax	20 Locality name

FOLD AND DETACH HERE

City or Local Filing Copy

W-2 Wage and Tax Statement **2025**

1 Wages, tips, other comp. 46455.45	2 Federal income tax withheld 3536.14
3 Social security wages	4 Social security tax withheld
5 Medicare wages and tips 52617.77	6 Medicare tax withheld 762.96
d Control number 0000005139 RPZ / Dept. / Corp. BJ00 / Employer use only E S 7876	
c Employer's name, address, and ZIP code: CITY OF ATLANTA 68 MITCHELL ST SW SUITE 6100 ATLANTA, GA 30303	
b Employer's FED ID number 58-6000511	a Employee's SSA number XXX-XX-0500
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12a DD 20358.26
14 Other 5928.78 BEN INS 6162.32 PEN PLANS 1009.32 STD INS	12b
	12c
	12d
	13 Stat emp. / Ret. plan X / 3rd party sick pa
e/f Employee's name, address and ZIP code: NASHALLE D NELSON 7182 WALTON HILL FAIRBURN, GA 30213	
15 State GA / Employer's state ID no. 0432896-TH	16 State wages, tips, etc. 46455.45
17 State income tax 1821.57	18 Local wages, tips, etc.
19 Local income tax	20 Locality name

2025 CITY OF SOUTH FULTON SOLID WASTE BILL

Arthur E. Ferdinand
Tax Commissioner, Fulton County

141 Pryor St SW
Atlanta, GA 30303
(404) 613-6100

Property Owner	Parcel Identification	Description	User ID
HOOD DERRICK T	13 -0162- LL-150-1	SOLID WASTE	ORG
	TAX DISTRICT:	55 SOUTH FULTON	

Property Address	Account Number	Service Period
7182 WALTON HILL SOUTH FULTON	6190798	06/01/2025 THROUGH 05/31/2026

EXEMPTIONS:

Control # 25875
WS_RWILLIA 27557802

Levies	Gross		Exemptions		Net Due
City Of South Fulton Solid Waste	233.16	-	.00	=	233.16

Total Billed for 2025	233.16
Less Amount Paid	.00
Total Due	$ 233.16

PAY THIS AMOUNT FOR TAX YEAR 2025. . . . . $ 233.16
FEES DUE FOR OTHER YEARS. . . . . $ .00
GRAND TOTAL DUE. . . . . $ 233.16

Failure to pay the amount shown by the due date will result in interest and /or penalties. Additional interest will continue to accrue each month until paid in full. Please read the enclosed for additional information and instructions or call our 24-hour customer service number at (404) 613-6100.

Parcel Identification	Property Address	Due Date	Solid Waste Amount Due
13 -0162- LL-150-1	7182 WALTON HILL SOUTH FULTON	07/31/2025	$233.16

WS_RWILLIA 27557802

RETURN COUPON WITH SOLID WASTE PAYMENT
MAKE YOUR CHECK PAYABLE TO:
FULTON COUNTY TAX COMMISSIONER

13 -0162- LL-150-1
HOOD DERRICK T
7182 WALTON HL
FAIRBURN GA 30213

Arthur E. Ferdinand
Tax Commissioner, Fulton County
P.O. Box 105052
Atlanta, GA 30348-5052
(404) 613-6100

619079803250070000023316 3

2025 CITY OF SOUTH FULTON SOLID WASTE BILL

Arthur E. Ferdinand
Tax Commissioner, Fulton County

141 Pryor St SW
Atlanta, GA 30303
(404) 613-6100

Property Owner	Parcel Identification	Description	User ID
HOOD DERRICK T	13 -0162- LL-150-1	SOLID WASTE	ORG
	TAX DISTRICT:	55 SOUTH FULTON	

Property Address	Account Number	Service Period
7182 WALTON HILL SOUTH FULTON	6190798	06/01/2025 THROUGH 05/31/2026

EXEMPTIONS:

Control # 25875
WS_RWILLIA 27557802

Levies	Gross		Exemptions		Net Due
City Of South Fulton Solid Waste	233.16	-	.00	=	233.16

Total Billed for 2025	233.16
Less Amount Paid	.00
Total Due	$ 233.16

PAY THIS AMOUNT FOR TAX YEAR 2025.	**$**	**233.16**
FEES DUE FOR OTHER YEARS.	$	.00
GRAND TOTAL DUE.	$	233.16

Failure to pay the amount shown by the due date will result in interest and /or penalties. Additional interest will continue to accrue each month until paid in full. Please read the enclosed for additional information and instructions or call our 24-hour customer service number at (404) 613-6100.

Parcel Identification	Property Address	Due Date	Solid Waste Amount Due
13 -0162- LL-150-1	7182 WALTON HILL SOUTH FULTON	07/31/2025	$233.16
		WS_RWILLIA 27557802	

RETURN COUPON WITH SOLID WASTE PAYMENT
MAKE YOUR CHECK PAYABLE TO:
FULTON COUNTY TAX COMMISSIONER

13 -0162- LL-150-1
HOOD DERRICK T
7182 WALTON HL
FAIRBURN GA 30213

Arthur E. Ferdinand
Tax Commissioner, Fulton County
P.O. Box 105052
Atlanta, GA 30348-5052
(404) 613-6100

619079803250070000023316 3

2025 TAX BILL

Arthur E. Ferdinand
Tax Commissioner, Fulton County

141 Pryor St SW
Atlanta, GA 30303
(404) 613-6100

Property Description **Property Address :** 7182 WALTON HILL

Fair Market Value - 309,100 **Assessed Value -** 123,640

Owner -**HOOD DERRICK T**

Parcel Number - 13 -0162- LL-150-1

Account Number - 6190798

Tax District - 55, SOUTH FULTON

City Exemptions -

County Exemptions - HF05-Fulton Veterans

County Tax Credit - $0.00

ORG
27603843
Control # 29,275

Levies	Assessment	Exemptions	Net Assessment	Net Rate		Net Tax
Fulton						
FULTON OPER	123,640 -	123,640 =	0 x	0.008870	=	0.00
FULTON BONDS	123,640 -	121,812 =	1,828 x	0.000169	=	0.31
FULTON SCHOOL GEN	123,640 -	123,640 =	0 x	0.017080	=	0.00
SOUTH FULTON	123,640 -	123,640 =	0 x	0.012399	=	0.00
				Total Billed for 2025		**0.31**
				Less Amount Paid		0.00
				Fulton Total Due		**$0.31**

PAY THIS AMOUNT FOR TAX YEAR 2025. . . . . $0.31

Please read the reverse side of the bill and enclosed brochure for additional information and instructions or call our 24-hour automated customer service line at (404) 613-6100.

Parcel Identification	Property Address	Due Date	Amount Due

Parcel Identification	Property Address	Due Date	Amount Due
13 -0162- LL-150-1	7182 WALTON HILL	11/15/2025	**$0.31**

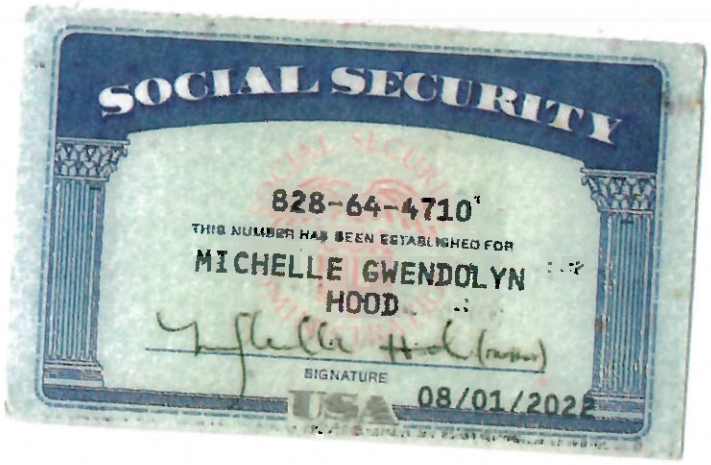
TC_GBRADF
27603843

Reason: COSF CALC

HOOD DERRICK T
7182 WALTON HL
FAIRBURN GA 30213

RETURN COUPON WITH FULTON PAYMENT
MAKE YOUR CHECK PAYABLE TO:
FULTON COUNTY TAX COMMISSIONER
Arthur E. Ferdinand
P.O. Box 105052
Atlanta, GA 30348-5052

619079803250020000000316


SOCIAL SECURITY
828-64-4710
THIS NUMBER HAS BEEN ESTABLISHED FOR
MICHELLE GWENDOLYN
HOOD
SIGNATURE
USA
08/01/2022

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH	Death Number	Local File Number	1. State File Number
			2022GA000067606

2.CHILD'S NAME: FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC.	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
MICHELLE GWENDOLYN HOOD	FEMALE	07/23/2022

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
00:31 MILITARY	SINGLE	

11.CITY,TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
ATLANTA	GRADY HEALTH SYSTEM
13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH
	FULTON

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST	18.MAIDEN (Last Name)
NASHALLE DENISE HOOD	NELSON

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
07/07/1983	GEORGIA	GEORGIA	FULTON

23. CITY,TOWN OR LOCATION.	24.STREET AND NUMBER OF RESIDENCE
FAIRBURN	7182 WALTON HILL

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
7182 WALTON HILL FAIRBURN GEORGIA 30213	YES

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A. ,Name Country)
DERRICK TAIWAN HOOD	04/16/1981	ALABAMA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
NASHALLE DENISE HOOD	MOTHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ SONDRA F SHANNON	07/25/2022	(Name) ANNAMARIA MAPLES 37.(Title) MD

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip)
(Name) SONDRA F SHANNON (Title)	0	80 JESSE HILL JR DRIVE SE ATLANTA GEORGIA 30303

41. REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ DAPHANIE SCANDRICK	07/25/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE **Form 3901A (Rev. 01/2013)**

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept unless on security paper with seal of Vital Records clearly embossed. Chapter 31-10, Code of Georgia as amended.

12849022

BY Daphanie Scandrick

S02742198

State Registrar

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

MAR 09, 2026

Form 3972 (Rev.5/15)

VOID IF ALTERED OR COPIED

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: NaShalle (first) Denise (middle) Nelson-Hood (last)

Child's Name: michelle (first) (middle) Hood (last)

Parent/ Guardian Contact Information:

Daytime phone number: _____

Evening phone number: _____

Cell phone number: 404. 484. 3924

Date of Birth: 07 / 23 / 2022 **Gender:** ☐Male ☑Female

Child's Home Address: 7182 (street) Walton Hill (street) Fairburn (city) Ga. (state) 30213 (zip code) Fulton (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) (MB)

All dental treatment completed.

Screening completed by:
- ☐ Physician
- ☑ Dentist
- ☐ Local Health Department Registered Nurse
- ☐ Registered Dental Hygienist
- ☐ School Registered Nurse

Melissa Burns, DDS 03-09-2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Children's Dental Sedation Center of Stockbridge
125 Eagles Pointe Pkwy Suite 110
Stockbridge, GA 30281
Phone 678.325.3354

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:

YMCA OF METRO ATLANTA

EARLY LEARNING

ALLERGY IDENTIFICATION FORM

CHILD'S NAME: Michelle G Hood **DATE OF BIRTH:** 07/23/2022

CLASSROOM TEACHER: _____ **FSA:** _____

IDENTIFIED ALLERGIES:

- ALLERGY Cows milk
- SKIN _____
- MEDICATION(S) _____
- PLANTS _____
- OTHER _____

ALLERGY TRIGGERS: Cows milk

REQUIRED TREATMENT FOR ALLERGIC REACTION: _____

PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION:

1. NAME Nashalle D Hood RELATIONSHIP TO CHILD mother
   PRIMARY TELEPHONE 404.484.3924 SECONDARY NUMBER _____
2. NAME Derrick T. Hood RELATIONSHIP TO CHILD father
   PRIMARY TELEPHONE 404.914.0972 SECONDARY NUMBER _____

CENTER ACTION PLAN:

FORM REVIEWED BY:

CENTER MANAGER: _____ **DATE:** _____

CLASSROOM TEACHER: _____ **DATE:** _____

FSA: _____ **DATE:** _____

CHILD HEALTH RECORD:

FORM 1, GENERAL INFORMATION

CHILD'S NAME: Michelle G. Hood **SEX:** F **BIRTHDATE:** 07/23/2022

HEAD START CENTER: KiDazzle Summit **PHONE:**

ADDRESS: 401 W Peachtree St.

NAME OF INTERVIEWER: **TITLE:**

1. PERSON INTERVIEWED: NaShalle D. Hood
   DATE _____, RELATIONSHIP TO CHILD Mother
2. CHILD'S NICKNAME, IF ANY Michii
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   _____
   _____ Zip Code _____
   PHONE _____
4. FATHER'S NAME Derrick T. Hood
5. MOTHER'S NAME NaShalle D. Hood
6. GUARDIAN'S NAME NaShalle D. Hood
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   _____
   PHONE _____, RELATIONSHIP _____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   1 English _____ Spanish
   _____ Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES (NO) EPSDT/Medicaid (Latest certification No.):
   _____
   YES (NO) Federal, State or Local Agency:
   _____
   YES (NO) In-Kind Provider: _____
   YES (NO) Other (3rd party): _____
   ID NO.: _____
   YES (NO) WIC
   YES (NO) Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    01/29/2026
11. DATE OF LAST VISIT TO DENTIST
    10/2025

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
    (Name, address, and phone no.):
    Physician Dr. Charlene Johnson
    Camp Creek Pediatrics
    Clinic _____
    _____
    Hospital ER _____
    _____
    Other _____
    _____
    Dentist _____
    _____

13. IN CASE OF EMERGENCY NOTIFY
    (1) Mary F. Nelson
    Relationship Grandmother
    Phone 404 453-1693 or _____
    (2) Tangela Ross
    Relationship Aunt
    Phone 404 429-8112 or _____
    (3) Mashelle D Nelson
    Relationship Aunt
    Phone 404 402 9687 or _____

14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites _____
    - ☐ Allergy, Medication _____
    - ☑ Other Allergy - Cows milk

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER Derrick Hood	4/16/88	✓		Sickle Cell Trait
MOTHER NaShalle Hood	7/7/88	✓		
BROTHERS & SISTERS *(oldest first)*				
(1) Paul Adams Jr	11/21/02	✓		
(2) Tonya Adams	2/2/04	✓		
(3) Stakey Adams	11/2/07	✓		
OTHER *(Specify relationship)*				
(1) Chasity Oliver	10/10/05	✓		Epilepsy
(2)				
(3)				

(Use additional page if needed)

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

INTERVIEWER: GO TO FORM 2A

CHILD HEALTH RECORD:

FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER: _____

CHILD'S NAME: Michelle G. Hood SEX: F BIRTHDATE: 07/23/2006

PERSON INTERVIEWED: NaShalle D. Hood DATE: _____ RELATIONSHIP: mother

NAME OF INTERVIEWER: _____ TITLE: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?	✓		IVF, Blood Clot, Pre-eclampsia
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?		✓	
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?		✓	
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?		✓	
5. WHAT WAS CHILD'S BIRTH WEIGHT?			7 lbs., 10 oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?		✓	
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?		✓	
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?	✓		
9. IS MOTHER PREGNANT NOW?		✓	*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?		✓	
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)?*		✓	
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?		✓	

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ___SORE THROAT; ___COUGH; ___URINARY INFECTIONS OR TROUBLE URINATING, ___STOMACH PAIN, VOMITING, DIARRHEA?		✓	
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)?*	*	✓	
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?		✓	*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?*	*	✓	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?		✓	
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*	✓	*If "yes" ask:* WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*		✓	WHAT MEDICINE? _____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? ___HOW OFTEN? ___
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME: _____)
21. HAS CHILD HAD: ___BOILS, ___CHICKENPOX, ✓ECZEMA, ___GERMAN MEASLES, ___MEASLES, ___MUMPS, ___SCARLET FEVER, ___WHOOPING COUGH?	✓		Eczema
22. HAS CHILD HAD: ___HIVES, ___POLIO?	*	✓	
23. HAS CHILD HAD: ___ASTHMA, ___BLEEDING TENDENCIES ___DIABETES, ___EPILEPSY, ___HEART/BLOOD VESSEL DISEASE, ___LIVER DISEASE, ___RHEUMATIC FEVER, ✓SICKLE CELL DISEASE?	* ✓		*If "yes", transfer information to Forms 1 and 5.* Sickle Cell Trait (S)
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)?* a WHEN EATING ANY FOODS? _____ b WHEN TAKING ANY MEDICATION? _____ c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____	* ✓		*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? Cows Milk WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERY-DAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?		✓	DESCRIBE: WHEN?

* *If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: _____ **DATE:** _____ **RELATIONSHIP:** _____

NAME OF INTERVIEWER: _____ **TITLE:** _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____NO, ✓YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____NO, _____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? Yes

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW? Ignore them

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE? Great

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN? Great

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ✓NO, _____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP		✓		
(b) CRAWL		✓		
(c) WALK		✓		
(d) TALK		✓		
(e) FEED AND DRESS SELF		✓		
(f) LEARN TO USE THE TOILET		✓		
(g) RESPOND TO DIRECTIONS		✓		
(h) PLAY WITH TOYS		✓		
(i) USE CRAYONS		✓		
(j) UNDERSTAND WHAT IS SAID TO HIM/HER		✓		

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? ✓NO, _____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? ✓NO, _____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? ✓NO, _____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? ✓NO, _____YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? ✓NO, _____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

YMCA OF METRO ATLANTA

EARLY LEARNING

CONSENT FOR EMERGENCY MEDICAL OR DENTAL TREATMENT

I, Nashalle D. Hood (Parent/Guardian), hereby give my consent for emergency medical or dental treatment services for my child Michelle G. Hood (Child's Name).

I consent for my child to be transported to and from the source of emergency treatment. I understand that this care may include examinations and any test which, in the opinion of the attending health care provider or dentist, deems necessary.

I agree that if my child incurs a deep laceration that may require sutures, or first aid services, I give my permission for this treatment to be provided by a qualified medical professional. **However, this does not give consent to perform surgical procedures without further informed consent from me.**

I have provided my child's school with emergency contact information (telephone numbers) that may be used to contact me or a designee in the event of a medical emergency.

First Year:	**Parent Signature**	01/15/2024	**Date**
First Year:	**Staff Signature**	8/2/24	**Date**
Second Year:	**Parent Signature**		**Date**
Second Year:	**Staff Signature**		**Date**
Third Year:	**Parent Signature**		**Date**
Third Year:	**Staff Signature**		**Date**

YMCA OF METRO ATLANTA

EARLY LEARNING

PERMISSION TO PERFORM SCREENINGS & EXAMINATIONS

I, NaShalle D. Hood (Parent Guardian), hereby give my consent for Michelle G. Hood (Child's Name)

To receive the indicated screenings, assessments and examinations listed below. I understand that the YMCA of Metro Atlanta Early Learning, in accordance with the Performance Standard, deems these services a requirement and necessary. I also understand that the Early Learning Program may provide the services directly or by Certified Contract Providers designated by the program and that I will be informed of any abnormal results.

I understand that if I provide the YMCA of Metro Atlanta Early Learning Program with documentation of any of the applicable screening(s) or examinations listed below it may not be necessary to utilize this consent form for services.

I understand that by giving consent for a physical exam, I am giving the YMCA of Metro Atlanta Early Learning program permission to perform the exam with my child suitably draped, in accordance with the American Academy of Pediatrics (AAP).

I give the YMCA of Metro Atlanta Early Learning Program permission to perform *required* exams and/or screenings.

	Yes	No		Yes	No
Physical Exam	☑	☐	Hearing Screening	☑	☐
Blood Pressure Reading	☑	☐	Vision Screening	☑	☐
Hemoglobin	☑	☐	Developmental Screening	☑	☐
Lead Screening	☑	☐	Behavioral Screening	☑	☐
Height / Weight Measurements	☑	☐	Speech Screening	☑	☐

NaShalle D. Hood — Signature of Parent/Legal Guardian — 01/15/2026 — Date

K. Harris — Family Services Assistant — 8/3/24 — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

DENTAL SERVICES IDENTIFICATION FORM

Child's Name: Michelle G. Hood Parent/Legal Guardian: WaShalle D. Hood

I understand that the YMCA of Metro Atlanta Early Learning Program requires a complete dental examination within (90) days of enrollment.

I also understand that if my child does not have a dental examination the Early Learning Program has contracted with licensed providers who may render these services to my child. I also agree to submit all required documentation (i.e. Medicaid card, Peach Care card, etc., if applicable) to the Family Services Assistant before my child's appointment.

I hereby give my permission to have Michelle G. Hood (Child's Name) examined by a licensed dentist contracted with the YMCA of Metro Atlanta Early Learning Program. I understand that the examinations may contain the following services:

Examination by a Licensed Dentist	X
Dental X-rays	X
Prophylaxis (teeth cleaned)	X

I further understand that I will be notified of the results of the dental examination and that I will be informed in writing if further follow-up treatment is required.

Parent/Legal Guardian Signature — Date: 01/15/2026

Staff Signature — Date: 8/13/26

OR

I HEREBY DECLINE FOR MY CHILD TO BE EXAMINED BY AN AGENCY CONTRACTED DENTIST. I understand that it is a requirement of The YMCA of Early Learning to have a complete dental examination and, therefore, I will accept the responsibility for my child receiving a dental exam. I will ensure that the YMCA of Early Learning receives a copy of my child's current dental exam results.

Parent/Legal Guardian Signature — Date

Staff Signature — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization:
With the exception 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 parent.

I give KiDazzle Summit (Name of Facility), permission to apply one or more of the following topical ointments/preparations to Michelle G. Head (Child's name) in 7 (Classroom) in accordance with the directions on the label of the container.

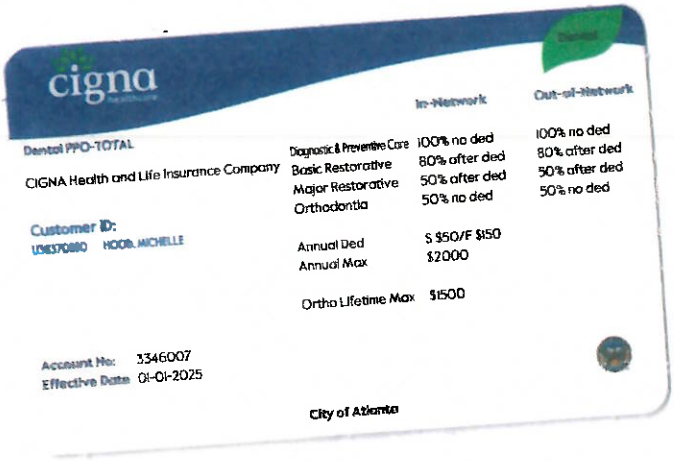
- ✓ Baby Wipes
- ✓ Band-aids
- ✓ Neosporin or similar ointment
- ✓ Bactine or similar first aid spray
- ✓ Sunscreen
- ✓ Insect Repellent
- ✓ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
- ✓ Baby Powder

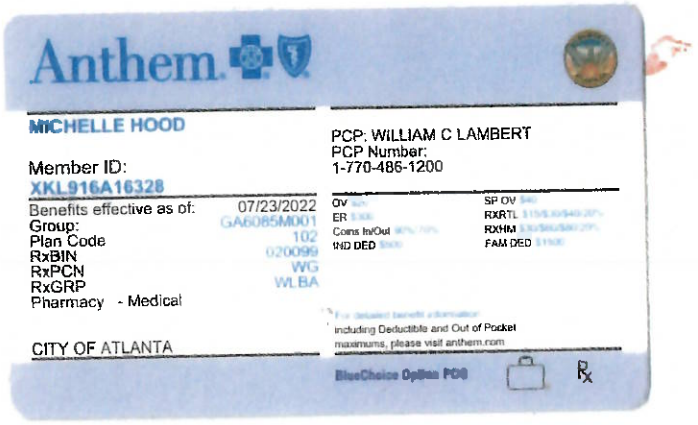
Other (please specify) _____

Michelle G. Head
Parent/Guardian Signature

01/15/2016
Date

*Center should maintain in Daily Health Check notebook.


cigna
Dental PPO-TOTAL
CIGNA Health and Life Insurance Company
Customer ID:
HOOD, MICHELLE
In-Network
Out-of-Network
Diagnostic & Preventive Care
Basic Restorative
Major Restorative
Orthodontia
100% no ded
80% after ded
50% after ded
50% no ded
100% no ded
80% after ded
50% after ded
50% no ded
Annual Ded
Annual Max
$ $50/F $150
$2000
Ortho Lifetime Max
$1500
Account No:
3346007
Effective Date
01-01-2025
City of Atlanta


Anthem
MICHELLE HOOD
Member ID:
XKL916A16328
Benefits effective as of:
07/23/2022
Group:
GA6085M001
Plan Code
102
RxBIN
020099
RxPCN
WG
RxGRP
WLBA
Pharmacy - Medical
CITY OF ATLANTA
PCP: WILLIAM C LAMBERT
PCP Number:
1-770-486-1200
OV
ER
Coins In/Out
IND DED
SP OV
RXRTL
RXHM
FAM DED
including Deductible and Out of Pocket
maximums, please visit anthem.com
BlueChoice Option POS
Rx

YMCA OF METRO ATLANTA
EARLY LEARNING

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Michelle G. Hood	07/23/2022	7182 Walton Hill Fairburn Ga. 30213
CHILD'S NAME	DATE OF BIRTH	ADDRESS

I, Mashalle D Hood, authorize the use or disclosure of the above-named individual's health information as described
(Parent/Guardian)
below.

1. The following individual or organization is authorized to make disclosure:
   Name/Organization: _____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   - Immunization record
   - Medication information
   - List of allergies
   - Most recent dental exam from _____
   - Most recent Health history and physical exam from_____
   - Nutrition Records (WIC, Assessments) from _____
   - Approval of returning to school
   - Specified lab results (Hemoglobin, Hematocrit, Lead or TB screening only)
   - Early Intervention record (Babies Can't Wait Program) _____
   - Disabilities records from _____
   - Medicaid, Peach Care or insurance eligibility _____
   - Other Specific Information must be written below_____

3. I understand that the information in my child's health record may include information related to my child's overall health status. It may also include information about behavioral or mental health services and other treatment.

4. The information may be disclosed to and used by the following individual or organization:

   Name: YMCA of Metro Atlanta EARLY LEARNING _____

   Address: _____ Telephone _____ Fax: _____

   For the purpose of _____

5. I understand that I have a right to revoke the authorization at any time. I understand that if I revoke this authorization I must do in writing. I understand that the revocation may not apply to information I have already disclosed or released prior to this authorization.

6. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure emergency medical treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal Confidentiality Rules.

Signature of Parent or Legal Guardian: Mashalle D Hood Date: 01/15/2024

Signature of Early Learning Staff: _____ Date: _____

WHITEFOOR

PEDIATRIC CONSENT FORM

understand that Whitefoord Inc. Health Centers and School Based Health Centers can provide comprehensive health services to my child. I also nderstand that I have the right to withdraw this consent at any time upon written notice to the medical director.

authorize (**check all services for which you consent**):

☑ Release of information from the child's medical record whenever necessary for payment, continued care or treatment, and ealthcare operations.

☑ further give consent for staff to examine the child's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.

☑ For my child to receive medical care including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease nanagement, referrals, and other minor office procedures.

☑ Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian

☑ For my child to receive dental care. This includes periodic dental examinations for my child, which may include screenings, hotographs, radiographs and any other acceptable methods for the dental evaluation and management of the child's dental health.

☑ For my child to receive behavioral health and counseling services, including one-on-one counseling, community resource referrals ind outreach and coordination of outside resources.

☑ Participation in health education sponsored/coordinated by Whitefoord Inc. (including, but not limited to: nutrition, sexual health, ealth and wellness, etc.

☑ That in the case of a medical emergency, I give permission to Whitefoord Health Centers to call emergency transport for my child.

n order for health center staff members to provide services, I authorize the school to release school records on a "need to know" basis to the Whitefoord Health and School Based Health Center staff members, and also for Whitefoord Health Center staff members to release medical ecords to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may nclude the following: immunization records, class schedules, parental contact, address, phone number, medical/behavioral health conditions, ealth screenings, medications, health care plans, or attendance information. The medical and mental health providers from Whitefoord Health Centers may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed below to release information to the Health Center staff members as needed. I hereby authorize the Health Center to provide the services as ndicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served egardless of the ability to pay. I hereby authorize Whitefoord Health Center staff members to release any medical records required by the nsurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, Health Center staff members will use and share my Personal Health Information (PHI) for: treatment of my child's health condition, maintaining the continuity of my child's care and payment for health services provided to my child, and routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the ocation(s) my child receives his/her health care services.

have read and understand the above information and give permission for the child's care as described. I understand that I have the right to opt the child out of any medical testing or treatment. This consent will last for three years or the duration of the child's time at their current school housing a Whitefoord School Based Health Center location.

Name of Parent or Legal Guardian (please print):	Name of Child (please print):
NaShalle Nelson-Hood	Michelle G. Hood
Signature of Parent or Legal Guardian:	Relationship to Child: Date:
Michelle Nelson-Hood	Mother 01/15/2024

ev. Aug, 2021

WHITEFOORD

LEASE WRITE CLEARLY

chool Based Health Center Consent

School: KiDazzle Summit
Grade: Pre-K
Homeroom Teacher:

'ATIENT INFORMATION

lame: Michelle S. Head **Date of Birth:** 07.23.2022
ddress: 7182 Walton Hill Fairburn Ga. 30213
Iome Phone: 404.484.3924 **Email address:** adnelsonhood@gmail.com
'arent (please circle) (Mom) Dad Other:
'hild lives with (please circle) Mom Dad Other: Both parents
:mergency Contact: Mary Nelson 404.453.1693
'hone: 404 453 1693 (Cell) Landline (please circle)
f unavailable, can Whitefoord discuss your child's personal health information with anyone else?
lame & Relationship to child: NaShalle Nelson-Head mother
'hone Number: 404 484 3924

nsurance Information:

nsurance carrier name: Anthem Blue Cross Blue Shield
D/Member Number: KZZ916A116328 Group Number: GA6085M024
'olicy Holder & Date of Birth: NaShalle Nelson 07/07/1983

The following is required because we receive Federal funding for providing services at a discount. This information is for tatistical purposes and will not be disclosed.

'otal household income:
'lease circle: Hourly Weekly Monthly Yearly
Number of people in the household: 7
f there is no insurance coverage, would you be interested in discounts based on a sliding scale? Yes No
Would you like someone to contact you about applying for the discount? Yes No
Services requested (please circle): Medical Dental Counseling or Behavioral Health Services
'atient Gender Identity (please circle): Male (Female)
'atient Race (please circle): American Indian - Alaskan Native – Asian - Native American - (Black) - White
Ethnicity (please circle): Hispanic/Latino - (Not Hispanic/Latino) - Unknown

'atient Medical History:

Allergies: Cow milk
'lease list any surgeries:

Medical conditions:

'lease circle answer
Asthma: Yes (No)
Diabetes Yes (No)
Other Yes (No) **Please explain if yes:**
Recent ER Visit (please circle): Yes (No)
If yes, please explain:
Reason for Visit:
'acility:
Current Medications:
'lease include doses, mgs, and how often taken
Do you have another Primary Care Provider? Yes No
'rovider's Name: Dr. Charlene Johnson (Camp Creek Pediatrics)
'rovider's Phone Number: 404.349.6758

arent Signature: Michelle Head **Date:** 01/15/2024

ev. Aug, 2021

School Parental/Guardian Consent and Release

STEP 1

Name of Child: Michelle G. Hood — Child Age: 3

School Name: KDazzle Summit

City: Fairburn — State: Ga — Zip: 30213

Email: ndnelsonhood@gmail.com — Phone: 404-484-3524

In each step below, please read and check one box only. Once Steps 2-4 are completed, please sign at Step 5.

STEP 2: Dental Screening

YES ☑ NO ☐

Your Child is being offered a **FREE DENTAL SCREENING** as part of the Bright Smiles, Bright Futures (BSBF) program sponsored by Colgate-Palmolive Company ("Colgate"). By checking the "**YES**" box in Step 2, you are stating that you understand and agree that:

Colgate is providing the dental screening as a public service and your Child is participating in the BSBF dental screening voluntarily and at their and your own risk;

You are releasing and discharging Colgate and anyone affiliated with Colgate, including, without limitation, the volunteer dental professionals who are conducting the screenings, from any and all liabilities, suits, costs, or expenses in any way relating to the participation of the Child in the BSBF dental screening program; and

This Release is governed by New York law and that no changes to this Consent and Release are valid unless executed in writing by both you and Colgate.

STEP 3: Release of Protected Health Information

YES ☑ NO ☐

I understand that by checking "**Yes**" and signing this form, I authorize the dentist, dental specialist, or health care provider/entity conducting the BSBF program dental screening to use and disclose my child's protected health information, either in electronic or hardcopy form, to (i) another dentist, dental specialist, or health care provider/entity for treatment purposes, (ii) his or her school or employees of the school (such as teachers or medical staff) for informational, record keeping, or reporting purposes, or (iii) Colgate for informational, record keeping, or reporting purposes.

I understand that signing this authorization is voluntary. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that this authorization is valid until revoked. I understand I have the right to revoke this authorization at any time by sending written notification to Colgate-Palmolive Company, 300 Park Avenue, NY, NY 10022, Attn: Bright Smiles, Bright Futures. I understand that a revocation is not effective to the extent that any entity has already relied on this authorization to use or disclose my child's health information as described above.

STEP 4: Photo Release

YES ☑ NO ☐

Read and complete Step 4 regardless of whether your Child is participating in the BSBF dental screening program described in Step 2:

We may be taking photos and/or video of your Child at the BSBF program. By checking the "**YES**" box in Step 4, you are agreeing that:

Colgate and its BSBF partners, and anyone affiliated with Colgate or its BSBF partners (the "Colgate and BSBF Partners"), can use the photos and/or videos taken of your Child at the BSBF program in any and all media worldwide for as long as they wish to do so, including in external-facing media such as websites, social media, or brochures. The photos and/or videos taken of your Child will only be used to promote, publicize, or describe the BSBF program or Colgate's and/or its BSBF partners' community service or social responsibility efforts.

The Colgate and BSBF Partners can edit photos and/or videos taken of your Child without prior approval by you, and that Colgate is the owner of any and all photos and/or videos taken of your Child at the BSBF program; and

You are releasing and agreeing to hold harmless Colgate and its BSBF partners from any and all liability resulting from the use of any photos and/or videos taken of your Child at the BSBF event, and that this Consent and Release is governed by New York law.

STEP 5

Parent or Legal Guardian (Print name): Nashalle Nelson-Hood

Signature (of Parent or Legal Guardian): Nashalle Nelson-Hood

Date: 01/15/2024

REMINDER! Please make sure you check either Yes or No in steps 2, 3 and 4.

The Family Health Centers of Georgia, Inc.

SCHOOL-BASED HEALTH CENTER PATIENT CONSENT FORM

School District

[ ] Clayton [ ] Douglas [✓] Fulton: College Park or Lake Forest (circle one) [ ] Banneker

Date: 01/15/2026

You must complete all information **USING INK, SIGN & DATE** in order for your child to receive healthcare services from the Health Center. It is your responsibility to notify us immediately of any changes in address, phone number or insurance.

PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name: Michelle (first) G. (middle initial) Hood (last)

Patient's Address: 7182 Walton Hall (street)

City: Fairburn **State:** Ga **Zip Code:** 30213

Patient's Social Security #: _____ **Date of Birth:** 07/23/2022 **Sex:** F

Birth Country: [✓] USA [ ] Other _____ **Primary Language:** [✓] English [ ] Other _____

School: KiDazzle Summit

Grade: Pre-K Remedial/Special Education [ ] Yes [ ] No

Contact #:

Home #: _____ Cell #: 404-484-3924

Work #: _____ Other #: _____

Parent/Guardian's Email: ndnelsonhood@gmail.com

Emergency Contact Name: Mary Nelson **Relationship to Patient:** Grandmother

Emergency Contact #:

Home #: _____ Cell #: 404 453 1693

Work #: _____ Other #: _____

INSURANCE INFORMATION

[ ] No Insurance [ ] Medicaid #: _____ [✓] Private Insurance

Please indicate insurance company's name for private insurance: Anthem BCBS

Member's Name (as listed on insurance card): NaShalle Nelson Policy #: KZZ916A116328

Group # GA6085M024 Address: 7182 Walton Hill Fairburn, Ga 30213

Your child may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? [ ] Yes [✓] No

HEALTH INFORMATION

Medical Conditions (physical, behavioral health, dental): [ ] Yes [ ] No

If yes, please list: _____

Allergies (medications, food, environmental): [✓] Yes [ ] No

If yes, please list: Cows Milk

Dental Appointment in the past year: [✓] Yes [ ] No

PATIENT DEMOGRAPHICS

Special Populations (Check all that apply.)

- [ ] Migrant Agricultural Worker/Farmer
- [ ] Public Housing (live in or access to)
- [ ] Seasonal Agricultural Worker/Farmer
- [✓] Veteran
- [ ] None of the above
- [ ] Choose not to disclose

Housing (Check all that apply.)

- [ ] Doubled Up (temporarily living with others)
- [ ] Homeless
- [ ] Other (hotel, motel, other day to day payment, etc.)
- [ ] Public Housing (live in or access to)
- [ ] Shelter
- [ ] Street (car, outdoors, makeshift housing)
- [ ] Transitional Housing
- [✓] None of the above
- [ ] Choose not to disclose

SELF REPORTED INCOME

Number of people living in household: 7 Household Income: _____ [✓] Choose not to Disclose

I hereby give consent for my child to continue to receive medical, behavioral and dental services (when available) from The Family Health Centers of Georgia's School-Based Health Center. I authorize any physicial-designated health professional, dentist or behavioral health provider working for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

NaShalle Nelson-Hood
Name of Parent or Legal Guardian (please print)

Michelle Hood
Name of Patient (please print)

X _____
Signature of Parent or Legal Guardian

mother
Relationship to Patient

Date: 01/15/2024

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: NaShalle (first) Denise (middle) Nelson-Hood (last)

Child's Name: Michelle (first) (middle) Hood (last)

Parent/ Guardian Contact Information:

Daytime phone number:

Evening phone number:

Cell phone number: 404. 484. 3924

Date of Birth: 07/23/2022 **Gender:** ☐Male ☑Female

Child's Home Address: 7182 Walton Hill (street) Fairburn (city) Ga (state) 30213 (zip code) Fulton (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

Charlene Johnson, M. 07-28-26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Camp Creek Pediatrics
3886 Princeton Lakes Way
Suite 260
Atlanta GA. 30331

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

Charlene Johnson, M. 07-28-26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Camp Creek Pediatrics
3886 Princeton Lakes Way
Suite 260
Atlanta GA. 30331

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: 3'1 Weight: 30lbs

BMI: 15.2 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

Charlene Johnson, M. 07-28-26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Camp Creek Pediatrics
3886 Princeton Lakes Way
Suite 260
Atlanta GA. 30331

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:

Screeners' Comments:

2025 CITY OF SOUTH FULTON SOLID WASTE BILL

Arthur E. Ferdinand
Tax Commissioner, Fulton County

141 Pryor St SW
Atlanta, GA 30303
(404) 613-6100

Property Owner	Parcel Identification	Description	User ID
HOOD DERRICK T	13 -0162- LL-150-1	SOLID WASTE	ORG
	TAX DISTRICT:	55 SOUTH FULTON	

Property Address	Account Number	Service Period
7182 WALTON HILL SOUTH FULTON	6190798	06/01/2025 THROUGH 05/31/2026

EXEMPTIONS:

Control # 25875
WS_RWILLIA 27557802

Levies	Gross		Exemptions		Net Due
City Of South Fulton Solid Waste	233.16	-	.00	=	233.16

Total Billed for 2025	233.16
Less Amount Paid	.00
Total Due	$ 233.16

PAY THIS AMOUNT FOR TAX YEAR 2025.	**$**	**233.16**
FEES DUE FOR OTHER YEARS.	$	.00
GRAND TOTAL DUE.	$	233.16

Failure to pay the amount shown by the due date will result in interest and /or penalties. Additional interest will continue to accrue each month until paid in full. Please read the enclosed for additional information and instructions or call our 24-hour customer service number at (404) 613-6100.

Parcel Identification	Property Address	Due Date	Solid Waste Amount Due
13 -0162- LL-150-1	7182 WALTON HILL SOUTH FULTON	07/31/2025	$233.16

WS_RWILLIA 27557802

RETURN COUPON WITH SOLID WASTE PAYMENT
MAKE YOUR CHECK PAYABLE TO:
FULTON COUNTY TAX COMMISSIONER

13 -0162- LL-150-1
HOOD DERRICK T
7182 WALTON HL
FAIRBURN GA 30213

Arthur E. Ferdinand
Tax Commissioner, Fulton County
P.O. Box 105052
Atlanta, GA 30348-5052
(404) 613-6100

61907980325007000000233163

YMCA OF METRO ATLANTA

EARLY LEARNING

HEALTH APPOINTMENT NOTIFICATION

Child's Name: Michelle Hood Date: 10/9/2026

Dear Parent / Guardian:

ABSOLUTE CARE PEDIATRICS will visit KIDazzle on October 23rd to complete physical exams. Thank you for filling out and returning the permission forms. Your child will receive the following exam(s) If you do not want your child seen, please have the physical exam submitted by **October 30, 2026**.

X **Physical Exam**

Please call me at (404) 753-8884 if you have questions.

Sincerely,

Family Services Assistant

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☒ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER
Michelle Hood	7/23/2022	Kidazzle

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE	
Charlene Johnson	MD 10-21-26	
CLINIC/TYPE OF PRACTICE	**TELEPHONE NUMBER**	**DATE OF EXAM**
Pediatrics	404-349-0758	7/28/26
ADDRESS		
3886 Princeton Lakes Way Suite 260 Atlanta GA 30331		

EXAMINATION RESULTS

HEIGHT	WEIGHT	BLOOD PRESSURE
3' 1/4 inches	30lbs lbs/oz	90/60

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin	✓		Mouth/Teeth/ Oral Health Assessment	✓		Genitalia	✓	
Head			Throat			Neurologic		
Neck			Chest			Extremities		
Lymph Nodes			Lungs			Motor Ability		
Eyes			Heart			Psychological		
Ears			Back	WNL		Speech		
Nose			Abdomen			Developmental		
						Behavioral		

Vision Acuity	Right	Left	Both	Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date 7/28/26	20/40	20/40	/	Date	7/28/26	1000 Hz	dB	dB
Test Type Snellen chart				Test Type		2000 Hz	dB	dB
						3000 Hz	dB	dB
						4000 Hz	dB	dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
7/30/24	10.1 12.8	☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	
		☒ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☒ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS			DATE READ
	mm	☐ Non Significant	☐ Significant	

DATE OF CHEST X-RAY			RX DATE
	☐ Normal	☐ Abnormal	

Lead Risk Assessment

☐ At Risk ☒ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:_____

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

WC 7/28/26

Treatment/Restrictions/Recommendations for School

ajax for Asthma Meds today

Does the child have asthma? ☐ Yes ☒ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☒ No (If yes, Medication Administration form needed)

TYPE OF MEDICATION AND PURPOSE

Child is physically and emotionally able to participate in program ☒ Yes ☐ No (If no, please explain in space above)

Peavy Creek Pediatrics
3886 Princeton Lakes Way
Suite 260
Atlanta GA. 30331

7/18 **Distribution:** **White – Child's File** **Canary – Parent**

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form:_____ **Staff Name:**_____

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Jackson, Lauryn Brielle	**State Student ID:** 2609529
Date of Birth: 11/05/21	**Classroom:** Room 7
Parent / Guardian: Tanea Anderson	**Contact Phone:** 404-432-6119

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Jackson_Lauryn_Brielle.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_8a641d.pdf	18	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	D4C 3300 Form Lauryn Jackson.pdf	1	✓ VERIFIED
4	**CACFP Income Eligibility Statement (IES)**	IES_Anderson_Lauryn_1790881207134.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609529
Student Name: Jackson, Lauryn Brielle	**Date of Birth:** 11/05/21
Parent(s)/Guardian: Tanea Anderson	**Phone:** 404-432-6119

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ RECEIVED	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609529

Scan the QR code or click the link above. Use child's Date of Birth (**11/05/21**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:

Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**

**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Jackson, Lauryn Brielle** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write school year in the box → 2026-27

Pre-K Registration Form School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME: KIDAZZLE - Summit	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Jackson			
CHILD'S FIRST NAME: Lauryn			
CHILD'S MIDDLE NAME: Brielle	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 692-62-1659	D.O.B. (MM/DD/BY): 2021-11-0	SEX:	M ☑ F
HOME ADDRESS (*Do not enter PO Box Info*): 2900 Pharr Court South NW	COUNTY:		
CITY: Atlanta	STATE: GA	ZIP: 30305	HOME PHONE: 4782937728

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: Anderson	FIRST: Tanea	MIDDLE INITIAL: N
Home Address (*If different from child*):		
City: Atlanta	State: GA	Zip: 30303
Home Phone: (478) 2937728	Cell Phone: ( ) 4782937728	
Email Address: taneanicole@icloud.com		
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.	A.Anderson	Grandmother	4785421361		
2.	Raven Lavender	Godmother	4785085325		

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.

Tanea Anderson

Signature Parent/Guardian: Tanea Anderson **DATE:** 2026-07-10

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): CHOA

DATE OF LAST FULL HEALTH SCREENING: 2025-07-25 PHONE: (404)7850210

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

Epilepsy; controlled by medication that is given at home

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

N/A

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:

Trileptal/7ml 2x a day; Keppra/6ml 2x a day; Epidiolex/2ml 2x a day

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-04 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Lauryn Brielle Jackson
_____
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑**Breakfast** ☑**Lunch** ☑**Afternoon Snack** ☑**Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Tanea Anderson

Parent/Guardian Signature: Tanea Anderson

Date: 2026-07-10

Facility Administrator Signature: K. Harris

Date: 8/3/26

Georgia Dept of Early Care and Learning

BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-07-10		
CHILD INFORMATION:		
Legal First Name: Lauryn		Name Suffix (Jr,II,III):
Legal Middle Name: Brielle		Name Child is Called:
Legal Last Name: Jackson		
Child's Social Security # 692621659	DOB (M/D/Y): 2021-11-05	Gender: M ☐ F ☑
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): 2026-08-04	
PARENT/GUARDIAN INFORMATION:		
Last Name: Anderson	First Name: Tanea	
Relationship: Mother ☑ Father	Grandparent	Guardian Other
Email Address: taneanicole@icloud.com	Zip Code: 30305	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino ☑ **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

Yes ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

☑ **Supplemental Nutrition Assistance Program (SNAP)**

☑ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

Yes ☑ **No**

Tanea Anderson

Tanea Anderson

Parent/Guardian Signature

2026-07-10

Date

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.

Tanea Anderson

SIGNATURE (Parent/Guardian): Tanea Anderson

DATE: 2026-07-10

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, Lauryn Brielle Jackson, 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: Tanea Anderson

SIGNATURE (Parent/Guardian): Tanea Anderson

DATE: 2026-07-10

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
   (i.) Provide information about the benefits of regular attendance.
   (ii.) Support families to promote the child's regular attendance.
   (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
   (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Tanea Anderson

Parent(s) or Guardians Signature: Tanea Anderson **Date:** 2026-07-10

Administrative Signature: K. Harris **Date:** 8/3/26

Teacher Signature: _____ **Date:** _____

L. Jackson

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note:** Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Jackson, Lauryn B	SNAP	☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Tanea Anderson	$0 _____/_____	$0 _____/_____	$ _____/_____	$ _____/_____
2. First and Last Name	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. First and Last Name	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. First and Last Name	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX 8017 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Circle the meals your child will normally receive while in care: ✓ Breakfast AM Snack Lunch ✓ PM Snack ✓ Supper Evening Snack

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. ***If not completed fully and signed, the participant will be placed in the Paid category.***

Signature: X _____ **Print Name:** Tanea Anderson **Date:** 2026-07-1

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only.*

Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility:** check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

Signature Certificate

Reference number: 14A3A27D-2609-4F25-A100-9ADFA43FBB01

Sent on July 9, 2026 7:51 PM UTC

Signed By	Signature
Tanea Anderson taneanicole@icloud.com Viewed: July 9, 2026 7:51 PM UTC Signed: July 10, 2026 2:08 PM UTC	 IP address: 2600:387:c:6e1b::7 Location: undefined, US

Document completed by all parties on
July 10, 2026 2:08 PM UTC

GEORGIA
DRIVER'S LICENSE

DRIVER'S LICENSE

DL

USA
GA

Governor:

Commissioner:



4d DL NO. 056932366
3 DOB 04/19/1995
9 CLASS C
4b EXP 04/19/2034
2 TANEA NICOLE
1 ANDERSON

8 104 JAMESTOWN DR
WARNER ROBINS, GA 31088-5691
HOUSTON

12 REST A
9a END NONE
4a ISS 03/09/2026
15 SEX F
18 EYES BRO
16 HGT 5'-03"
17 WGT 155 lb



04/19/1995

5 DD 630062102170020000

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number	Local File Number	1. State File Number
		2021GA000104829

2.CHILD'S NAME: FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
LAURYN BRIELLE JACKSON	FEMALE	11/05/2021

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10 IF NOT SINGLE SPECIFY BIRTH ORDER
08:27 MILITARY	SINGLE	

11.CITY,TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
WARNER ROBINS	HOUSTON MEDICAL CENTER
13. IF NOT HOSPITAL,Specify	**14. COUNTY OF BIRTH**
	HOUSTON

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST	18.MAIDEN (Last Name)
TANEA NICOLE ANDERSON	ANDERSON

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
04/19/1995	GEORGIA	GEORGIA	HOUSTON

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
WARNER ROBINS	2006 KARL DRIVE 1202

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
2006 KARL DRIVE 1202 WARNER ROBINS GEORGIA 31088	YES

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A.,Name Country)
MONTEZ JAQUAN JACKSON	06/29/1994	GEORGIA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
TANEA ANDERSON	MOTHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ BRITTNEY MITCHELL	11/08/2021	(Name) STACEY STOUT 37.(Title) CNM/CM

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip)
(Name) BRITTNEY MITCHELL (Title) BIRTH RECORD CLERK		1601 WATSON BOULEVARD WARNER ROBINS GEORGIA 31093

41. REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	11/08/2021

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE **Form 3901A (Rev. 01/2013)**

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS

Any reproduction of this document is prohibited by statute. Do not accept this document unless the Vital Records clearly embossed. Chapter 31-10 Code of Georgia as amended.

Christopher JP Harrison 6217621
State Registrar

Lisa Adkison
County Registrar

STATE OFFICE GA VITAL RECORDS

C6507317

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

DEC 02 2021

STATE OF GEORGIA 1776

Form 3972 (Rev 5/15)

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR COPIED

Hello Tanea Anderson,

Welcome to Xfinity. We're excited to provide award-winning services we think you'll love.

Your bill at a glance

For 2900 PHARR COURT SOUTH NW, APT 3106, ATLANTA, GA, 30305-4965

Previous balance		$0.00
Payments		$0.00
Balance forward		**$0.00**
Regular monthly charges	Page 3	$29.95
One-time charges	Page 3	$0.00
Taxes, fees and other charges		$0.00
New charges		**$29.95**
Amount due		**$29.95**

Thanks for paying by Automatic Payment

Your automatic payment on Jul 09, 2026, will include your amount due, plus or minus any payment related activities or adjustments, and less any credits issued before your bill due date.

Need help?

Visit xfinity.com/customersupport or see page 2 for other ways to contact us.

Your bill explained

- This page gives you a quick summary of your monthly bill. A detailed breakdown of your charges begins on page 3.

Detach the bottom portion of this bill and enclose with your payment

Please write your account number on your check or money order

Do not include correspondence with payment

xfinity

2605 CIRCLE 75 PWKY SE
ATLANTA GA 30339-4268

TANEA ANDERSON
2900 PHARR COURT SOUTH NW APT 3106
ATLANTA, GA 30305-4965

Account number	**8220 18 893 2653496**
Automatic payment	Jul 09, 2026
Please pay	**$29.95**

Credit card payment will be applied Jul 09, 2026

COMCAST
PO BOX 71211
CHARLOTTE NC 28272-1211

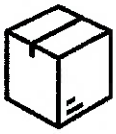
822018893265349600029959

Move in a minute

Transfer your services in a few simple steps.

It's easy to schedule your move in just about a minute. On the way, you'll stay connected with our WiFi hotspots.

Learn more at **xfinity.com/moving**.



Manage your account settings anytime, anywhere

Easily update your information on all your devices:

1. **Online:** Sign in at xfinity.com/account.
2. **On your smartphone:** Go to xfinity.com/apps and download our free Xfinity app.
3. **On your TV:** Open your X1 Main Menu and navigate to your account under Apps.

Contact us

We're here to help.

Chat
Visit xfinity.com/chat

Social
Tweet us @XfinitySupport

App
Download the Xfinity app at xfinity.com/apps or in your app store

Phone
Call 1 800 xfinity (1 800 934 6489)

Store
At your nearest Xfinity store
find one at xfinity.com/storelocator

Additional information

Moving?

Visit xfinity.com/moving today to help you stay connected to all of your Xfinity services.

Accessibility:

If you are hearing impaired, call 711. For issues affecting members with disabilities, including requesting communications in large print or braille, call 1-855 270 0379, chat live at support.xfinity.com/accessibility, email accessibility@comcast.com, fax 1-866 599 4268 or write to Comcast at 1701 JFK Blvd., Philadelphia, PA 19103 2838 Attn: M. Gifford.

Ways to pay

Looking to shorten your to-do list?

Set up automatic monthly payments and never worry about remembering to pay your bill again. Enrolling is fast, easy, and free at **xfinity.com/autopay**.

Hello paperless billing, goodbye clutter

With paperless billing, you can pay and view your bill online. It's faster, easier and helps cut down the clutter, not the trees! Visit xfinity.com/ecobill to go green.

Additional billing information

Other ways to pay

Visit xfinity.com/myaccount and use the Xfinity app

Regular monthly charges $29.95

My Xfinity plan $29.95

Internet: Internet Essentials Plus $29.95

Equipment & services $0.00

Internet/Voice Equipment Rental.		Included

One-time charges $0.00

Installation fees $0.00

Getting Started Kit Internet.	Jun 18	$0.00

What's included?

Internet: Internet Essentials Plus

Visit xfinity.com/myaccount for more details

SSNAP Printout for Replacement Social Security Number Card **Ref:** 22147005171

Number Holder Name: LAURYN, BRIELLE, JACKSON
Name at Birth:
Other Name(s):

Name to be shown on card: LAURYN BRIELLE JACKSON
Sex: F
Birth Date: 11/05/2021
Place of Birth: WARNER ROBIN, GA
Parent / Mother's Name at Her Birth: TANEA NICOLE ANDERSON
Parent / Mother's SSN:
Parent / Father's Name: MONTEZ JAQUAN JACKSON
Parent / Father's SSN:

Has the number holder or anyone acting on his/her behalf ever filed for or received a Social Security Number Card before? Yes

Citizenship: US
Last SSN: 692621659
Birth Date on Prior Application: 11/05/2021
Name Shown on Last Card: LAURYN BRIELLE JACKSON

Mailing Address: 2006 KARL DR APT 1202
WARNER ROBINS GA 31088-9418
Telephone: 478-293-7728
Ext:

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

JACKSON, LAURYN BRIELLE
Child's Name (Last name, First name)

11 | 05 | 2021
Birthdate

07/01/2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

( ) (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

( ) (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

( ) (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	01 07 22	03 08 22	05 10 22	02 15 23			4				
Polio	01 07 22	03 08 22	05 10 22	02 15 23			4				
Hepatitis B	11 05 21	01 07 22	03 08 22	05 10 22			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	01 07 22	03 08 22	05 10 22	02 15 23			4				
PCV (Under Age 5)	01 07 22	03 08 22	05 10 22	11 09 22			4				
Measles	11 09 22						1				
Mumps	11 09 22						1				
Rubella	11 09 22						1				
Hepatitis A (Born on/after 1/1/06)	11 09 22	05 05 23					2				
Varicella	11 09 22						1				
Recommended Vaccines (For Information Only)											
Rotavirus	01 07 22	03 08 22	05 10 22				3				
HPV							0				
Influenza	10 06 22						1				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Certified by (Signature/Signature Stamp) **Date of Issue**

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

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: Lauryn B Jackson
first middle last

Date of Birth: 11 / 05 / 2021 **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:

Not Applicable-Dental ONLY

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:

Not Applicable-Dental ONLY

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

02/02/2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Dentistry For Children Corporate Service Center
1350 Spring Street NW, 6th Floor
Atlanta, GA 30309
770-692-1000

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:

Not Applicable-Dental ONLY

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:

peach state health plan

Envolve Pharmacy Solutions

Pharmacy Help Desk: 1-844-297-0513

Name: LAURYN JACKSON

DOB: 11/05/2021

PCP: Amer Al Rafati

Phone:

Address:
1275 S Houston Lake Road Suites 1 and 2
Warner Robins, Georgia 31088

Medicaid ID: 222118866803

RXBIN: 004336

RXPCN: MCAIDADV

RXGROUP: RX5439

After Hours Phone:

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Peach State Health Plan for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or the Nurse Advice Line toll-free at 1-800-704-1484 (TDD/TTY 1-800-255-0056). The Nurse Advice Line is open 24 hours a day.

IMPORTANT MEMBER TELEPHONE NUMBERS

Some services may be limited and need a doctor's order. Some need prior approval. If you have questions, call us at 1-800-704-1484 or TDD/TTY 1-800-255-0056.

Algunos servicios pueden estar limitados y necesitan prescripción médica. Algunos servicios requieren autorización previa. Si tiene alguna pregunta, llámenos al 1-800-704-1484 o a la línea TDD/TYY al 1-800-255-0056.

Member Services/ Vision Services/ Dental Services/ Nurse Advice Line / Prescription Drugs
1-800-704-1484 TDD/TTY: 1-800-255-0056

FOR PROVIDERS

Eligibility: 1-800-704-1484;

Behavioral Claims: 1-800-947-0633

Medical Claims: Peach State Health Plan PO Box 3030/ Farmington, MO 63640-3812;

Dental Claims: P.O. Box 22085/Tampa, FL 33622, 1-844-464-5632;

Vision Claims: P.O. Box 7548/Rocky Mount, NC 27804;

Pharmacy Help Desk: 1-844-297-0513

Provider/claims information via the web: pshp.com

Note: Unless you are exempt from co-payments as listed on the front of this card, you may have a smallco-payment when you get certain kinds of care. You are not responsible for paying for covered services. Noone can deny you a covered service if you can't pay for it.

Do you need help understanding this? If you do call Peach State's Member Service Department at thenumber listed above. To get this information in large font or to have this information read to you over thephone, please call Member Services.

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: Lauryn B Jackson
first middle last

Date of Birth: 11 / 05 / 2021 **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:

Not Applicable-Dental ONLY

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:

Not Applicable-Dental ONLY

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

02/02/2026
_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Dentistry For Children Corporate Service Center
1350 Spring Street NW, 6th Floor
Atlanta, GA 30309
770-692-1000

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:

Not Applicable-Dental ONLY

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:

DPH Form 3300 Rev. 2013

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply.** (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Jackson, Lauryn	SNAP Case #136595983	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Tanea Anderson (Categorical SNAP/TANF Eligible)	$ WAIVED/_____	$ _____/_____	$ _____/_____	$ _____/_____
2. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II 2

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX_____ ☒ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of 6:30 AM [am/pm] to 6:00 PM [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday** **Monday** **Tuesday** **Wednesday** **Thursday** **Friday** **Saturday**

Circle the meals your child will normally receive while in care: **Breakfast** **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

PART IV: Signature
*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category**.*

Signature: X _____ **Print Name:** Tanea Anderson **Date:** 10/01/2026

Address: 2900 Pharr Court South NW, Apt 3106 **City:** Atlanta, GA **State:** _____ **Zip:** 30305 **Phone:** (478) 293-7728

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: SNAP Waived **Per**: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size**: 2

Categorical Eligibility: check (✓) if applicable ☒ **Eligibility**: check (✓) one Free ☒ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date**: 10/01/2026

Confirming Official's Signature: _____ **Date**: _____

Follow Up Official's Signature: _____ **Date**: _____

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Johnson, Marquis Adra	**State Student ID:** 2609491
Date of Birth: 01/08/22	**Classroom:** Room 7
Parent / Guardian: Katrina Highsmith-Johnson & Marquis Johnson	**Contact Phone:** 404-453-2940

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Johnson_Dementia_Nicole.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_13a055.pdf	34	✓ ON FILE
3	**Child Social Security Card**	image.jpg	1	✓ VERIFIED
4	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	img20260923_10523031.pdf	2	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Date: September 15, 2026	**Classroom:** Room 4 (Site ID: 33915)
Student Name: Johnson, Dementia Nicole	**Date of Birth:** 12/15/2021
Parent(s)/Guardian: Shuntae Hunter	**Phone:** 404-513-8890

Dear Parent/Guardian,

Under **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all students attending Georgia's Pre-K Program must have complete, state-mandated documentation on file at the center. During our compliance and data collection audit, the documentation below was identified as missing or incomplete for your child.

ACTION REQUIRED — OUTSTANDING ITEMS NEEDED:

- **Child Birth Certificate Copy**
- **Proof of Residency**
- **Parent Photo ID**
- **Form 3231 (Immunization)**
- **Form 3300 (Ear, Eye, Dental Screening)**

Important Guidelines for Required Documents:

- **Form 3300 (Screening):** Must include all four components (Ear/Hearing, Eye/Vision, Dental, and Nutrition). Blood pressure and lead screening must be recorded.
- **Form 3231 (Immunizations):** Must be a current Georgia Certificate of Immunization with valid expiration date or marked 'Complete for School'.
- **Proof of Residence:** Current gas, electric, or water utility bill (dated within 30 days) or valid lease agreement showing matching home address.
- **Social Security / 30-Day Waiver:** If an official 30-day waiver was signed, the physical card or proof of card order from SSA must be presented before the grace period expires.

COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please submit clear, readable copies immediately to ensure your child's enrollment remains in active standing with Georgia DECAL.

- **Email Submissions:** Send scanned copies or clear photos directly to **Ms. Karen Harris** at: karenharris@kidazzle.com
- **In-Person Submissions:** Hand-deliver original documents or copies to the Administrative Front Desk.
- **Questions / Support:** Call Ms. Harris at **(404) 753-8884** or mobile at **(404) 884-1483**.

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Johnson, Dementia Nicole** Parent Signature: _____ Date: _____

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-2027 **School Year**

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	Kidazzle - Summit

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**
CHILD'S LAST NAME:	JOHNSON
CHILD'S FIRST NAME:	MARQUIS
CHILD'S MIDDLE NAME:	ADRIAN — NAME SUFFIX: (i.e. Jr, Sr, II, III)
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY): 01/18/22 SEX: [X] M [ ] F
HOME ADDRESS (*Do not enter PO Box Info*):	820 N. Marietta St. NW COUNTY: Fulton
CITY: Atlanta	STATE: GA ZIP: 30318 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:	Highsmith-Johnson	FIRST: Katrina	MIDDLE INITIAL: A
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: (850) 340-9600	
Email Address:	katrina.highsmith@gmail.com		
Place of Employment:	Atlanta Development Authority	Work Phone: (678) 373-9279	
Address:	133 Peachtree St.		
City: Atlanta	State: GA	Zip: 30303	
Parent/Guardian #2 - LAST NAME:	Johnson	FIRST: Marquis	MIDDLE INITIAL: A
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: ( )		Cell Phone: (602) 820-6528	
Email Address:	Quis2425@me.com		
Place of Employment:	Retired	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.	Cymone Coker	Family Friend	609-418-9804		Cymonecoker@yahoo.com
2.	Denise Highsmith	Grandmother	856-889-9077		Denise.Highsmith@comcast.net

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: Katrina Highsmith-Johnson **DATE:** 1/16/26

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.	Cymone Coker	Smyrna, GA	friend	609-418-9804
2.	Denise Highsmith	Deptford, NJ	Grandmother	856-889-9077
3.	Thomas Highsmith	Myrtle Beach, SC	Grandfather	856-266-1846
4.	Melissa Anderson	Orlando, FL	Aunt	407-902-9907

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Dr. Rosena Miller

DATE OF LAST FULL HEALTH SCREENING: Feb 2025 PHONE: (770) 384-9830

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

N/A

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

N/A

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:

N/A

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): Katina Highsmith-Johnson

DATE: 1/16/26

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, Marquis Johnson, 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: hidazzle, 401 W. Peachtree St. ATL, GA 30308

SIGNATURE (Parent/Guardian): Katina Highsmith-Johnson

DATE: 1/16/26

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1. KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 8/26 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Marquis Johnson
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ 50 **per week.** (After care)

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast **Lunch** **Afternoon Snack** **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: Katrina Haysmith Johnson

Date: 1/16/26

Facility Administrator Signature: K. Hays

Date: 8/3/24

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Re[illegible]ter Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 1/26/26		
CHILD INFORMATION:		
Legal First Name: Marquis		Name Suffix (Jr,II,III): Jr.
Legal Middle Name:		Name Child is Called: MJ
Legal Last Name: Johnson		
Child's Social Security # [illegible] - -	DOB (M/D/Y): 1/18/22	Gender: M ☑ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): / /	
PARENT/GUARDIAN INFORMATION:		
Last Name: Highsmith-Johnson	First Name: Katrina	
Relationship: Mother ☑ Father ☐	Grandparent ☐ Guardian ☐ Other ☐	
Email Address: katrina.highsmithe gmail.com	Zip Code: 30318	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

Katrina Highsmith-Johnson
Parent/Guardian Signature

Date 1/26/26

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
   (i.) Provide information about the benefits of regular attendance.
   (ii.) Support families to promote the child's regular attendance.
   (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
   (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 1/25/26

Administrative Signature: _____ **Date:** 8/3/24

Teacher Signature: _____ **Date:** _____


GEORGIA
DRIVER'S LICENSE
DRIVER'S LICENSE
DL
USA
GA
Governor:
Commissioner:
4d DL NO. 056817631
3 DOB 05/25/1987
9 CLASS C
4b EXP 05/25/2025
2 KATRINA ALLESE
1 HIGHSMITH
8 820 W MARIETTA ST NW APT 1475
ATLANTA, GA 30318-8043
FULTON
12 REST A
9a END NONE
4a ISS 02/10/2024
15 SEX F
18 EYES BRO
16 HGT 5'-03"
17 WGT 130 lb
05/25/1987
5 DD 554286683700020000

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK — HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number	Local File Number	1 State File Number
		2022GA000005885

2.CHILD'S NAME FIRST 3.MIDDLE 4.LAST 5.JR, III,ETC	6.SEX (M or F)	7.DATE OF BIRTH (Mo. Day, Year)
MARQUIS ADRIAN JOHNSON JR	MALE	01/18/2022

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
12 12 MILITARY	SINGLE	

11.CITY, TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital, give Street and Number.)
ATLANTA	EMORY UNIVERSITY HOSPITAL MIDTOWN
13. IF NOT HOSPITAL Specify	14. COUNTY OF BIRTH
	FULTON

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST	18.MAIDEN (Last Name)
KATRINA ALLESE HIGHSMITH	HIGHSMITH

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A. Name Country)	21.RESIDENCE - STATE	22. COUNTY
05/25/1987	PENNSYLVANIA	GEORGIA	COBB

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
SMYRNA	300 HICKORY SPRINGS DRIVE SE

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
300 HICKORY SPRINGS DRIVE SE SMYRNA GEORGIA 30082	NO

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A.,Name Country)
MARQUIS ADRIAN JOHNSON	05/18/1988	FLORIDA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
KATRINA A HIGHSMITH	MOTHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ TIFFANY DUNCAN	01/19/2022	(Name) ELIZABETH COLLINS 37.(Title) MD

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town, State, Zip)
(Name) TIFFANY DUNCAN (Title) VITAL RECORDS COORDINATOR		650 PEACHTREE STREET NE ATLANTA GEORGIA 30308

41. REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	01/21/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE — Form 3901A (Rev. 01/2013)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER CODE OF GEORGIA AND 511-1-3 DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept ... records clearly enclosed. Chapter 31-10, Code of Georgia amended.

7339015

BY AUG 11 2022

State Registrar

STATE OFFICE GA VITAL RECORDS

S2143467

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

STATE OF GEORGIA 1776

Form 3872 (Rev. 5/15)

VOID IF ALTERED OR COPIED

APARTMENT LEASE CONTRACT

Equal Housing Opportunity Provider

Date of Lease Contract: July 15, 2025
(when the Lease Contract is filled out)

This is a binding document. Read carefully before signing.

Moving In — General Information

1. **PARTIES.** This Lease Contract (sometimes referred to as the "lease") is between *you*, the resident(s) *(list all people signing the Lease Contract):*

Katrina Highsmith

and *us*, the owner: 820 W Marietta Owner LLC

(name of apartment community or title holder). You've agreed to rent apartment No. 1475, at 820 West Marietta Street NW # 1475 *(street address)* in Atlanta *(city)*, Georgia, 30318 *(zip code)* (the "apartment" or the "premises") for use as a private residence only. The terms "you" and "your" refer to all residents listed above. The terms "we," "us," and "our" refer to the owner listed above (or any of owner's successors' in interest or assigns). Written or electronic notice to or from our managers constitutes notice to or from us. If anyone else has guaranteed performance of this Lease Contract, a separate Lease Contract Guaranty for each guarantor is attached.

2. **OCCUPANTS.** The apartment will be occupied only by you and *(list all other occupants not signing the Lease Contract):*

Marquis Johnson

No one else may occupy the apartment. Persons not listed above must not stay in the apartment for more than 14 consecutive days without our prior written consent, and no more than twice that many days in any one month. If the previous space isn't filled in, two days per month is the limit.

3. **LEASE TERM.** The initial term of the Lease Contract begins on the 15th day of July, 2025, and ends at 11:59 p.m. the 14th day of July, 2026.

Renewal. This Lease Contract will automatically renew month-to-month unless either party gives at least 60 days written notice of termination or intent to move-out as required by paragraph 46 (Move-Out Notice). If the number of days isn't filled in, at least 30 days notice is required. In the event this Lease Contract has renewed on a month-to-month basis, it shall continuously renew each month thereafter until either party provides the other with a written notice of termination at least 30 days before the end of any such renewal term in accordance with the requirements set forth in Paragraph 46 (Move-Out Notice).

4. **SECURITY DEPOSIT.** Unless modified by addenda, the total security deposit at the time of execution of this Lease Contract for all residents in the apartment is $ 0.00, due on or before the date this Lease Contract is signed.

Your security deposit will be *(check one)*

☒ **placed in an account at (state the bank's name)** Fifth Third Bank **located at (state the bank's address)** 1 S Wacker Chicago, IL 60606;

OR

☐ **secured by a bond which is on file with the** _____ **(County) Clerk of Superior Court.**

In the event interest is earned on the security deposit, Owner may keep the interest.

5. **KEYS.** You will be provided 2 apartment key(s), 2 mailbox key(s), 1 FOB(s), and/or _____ other access device(s) for access to the building and amenities at no additional cost at move-in. If the key, FOB, or other access device is lost or becomes damaged during your tenancy or is not returned or is returned damaged when you move out, you will be responsible for the costs for the replacement and/or repair of the same.

6. **RENT AND CHARGES.** Unless modified by addenda, you will pay $ 1672.00 per month for rent, payable in advance and without demand:

☐ at the on-site manager's office, or
☒ at our online payment site, or
☒ at www.porterwestsideatl.com

Prorated rent of $ 916.90 is due for the remainder of *(check one)*: ☒ 1st month or ☐ 2nd month, on January 31, 2024.

Otherwise, you must pay your rent on or before the 1st day of each month (due date) with no grace period. Cash is unacceptable without our prior written permission. You must not withhold or offset rent unless authorized by statute. We may, at our option, require at any time that you pay all rent and other sums in cash, certified or cashier's check, money order, or one monthly check rather than multiple checks. At our discretion, we may convert any and all checks via the Automated Clearing House (ACH) system for the purposes of collecting payment. Rent is not considered accepted, if the payment/ACH is rejected, does not clear, or is stopped for any reason. If you don't pay all rent on or before the 3rd day of the month, you'll pay a late charge. Your late charge will be *(check one)*: ☐ a flat rate of $ 167.20 or ☒ 10 % of your total monthly rent payment. Regardless of the calculation method chosen above, the total amount of your late charges shall not exceed ten percent (10%) of your monthly rent payment. You'll also pay a charge of $ 75.00 (or the maximum amount allowed by law as of the time the check is rendered) for each returned check or rejected electronic payment, plus a late charge. If you don't pay rent on time, you'll be delinquent and all remedies under state law and this Lease Contract will be authorized. We'll also have all other remedies for such violation.

The failure to pay rent timely or the violation of the animal restrictions will result in added administrative and other expenses to us. Since such additional expenses are difficult to determine, late fees and animal violation charges are considered liquidated damages. The amount of such fees and charges are reasonable estimates of the administrative and other expenses we would incur. Animal violation charges do not cover damages to the premises and don't limit your liability for same. All payment obligations under this Lease Contract shall constitute rent under this Lease Contract.

7. **UTILITIES.** We'll pay for the following items, if checked:
☐ water ☐ gas ☐ electricity ☐ master antenna
☐ wastewater ☐ trash ☐ cable TV
☐ other _____

© 2024, National Apartment Association, Inc. - 2/2024, Georgia

You'll pay for all other utilities, related deposits, and any charges, fees, or services on such utilities. We must not allow utilities other than cable TV not provided by us to be disconnected for any reason—including disconnection for not paying your bills—until the lease term or renewal period ends. Cable channels that are provided may be changed during the Lease Contract term if the change applies to all residents. If the property is currently providing cable to the resident, the property may, with 30 days notice to the resident, cease providing cable and the resident will contract directly with the cable provider for such services. Utilities may be used only for normal household purposes and must not be wasted. If your electricity is ever interrupted, you must use only battery-powered lighting. If any utilities are submetered for the apartment, or prorated by an allocation formula, we will attach an addendum to this Lease Contract in compliance with state or local law. You must not heat the apartment using gas-operated stoves or ovens which were intended for use in cooking.

**Important Disclosure Regarding Management's Right to Select the Natural Gas Marketer (Provider). Resident (the Tenant) authorizes Management (the Landlord) to act as Resident's agent for the limited purpose of selecting the Resident's natural gas marketer, to authorize the natural gas marketer to obtain credit information on the Resident, if required by the marketer, and to enroll the Resident on the marketer's standard variable price plan for which the Resident is eligible, unless the Resident chooses another price plan for which the resident is eligible. Resident acknowledges that Management may have business relationship with the natural gas marketer that may provide for a financial or other benefit to Management in exchange for the Resident's enrollment with the Marketer.

8. **INSURANCE.** We do not maintain insurance to cover your personal property or personal injury. We are not responsible to any resident, guest, or occupant for damage or loss of personal property or personal injury from (including but not limited to) fire, smoke, rain, flood, water and pipe leaks, hail, ice, snow, lightning, wind, explosions, earthquake, interruption of utilities, theft, hurricane, negligence of other residents, occupants, or invited/uninvited guests or vandalism unless otherwise required by law.

   In addition, we urge all residents, and particularly those residing in coastal areas, areas near rivers, and areas prone to flooding, to obtain flood insurance. Renter's insurance may not cover damage to your property due to flooding. A flood insurance resource which may be available includes the National Flood Insurance Program managed by the Federal Emergency Management Agency (FEMA).

   We urge you to get your own insurance for losses to your personal property or injuries due to theft, fire, water damage, pipe leaks and the like.

   Additionally, you are *[check one]* ☒ required to purchase personal liability insurance ☐ not required to purchase personal liability insurance. If no box is checked, personal liability insurance is not required. If required, this policy must list Owner as an additional insured and failure to maintain personal liability insurance throughout your tenancy, including any renewal periods and/or lease extensions, is an incurable breach of this Lease Contract and may result in the termination of tenancy and eviction and/or any other remedies as provided by this Lease Contract or state law.

   You acknowledge that no portion of the rent paid by you under this agreement will be specifically allocated for the purchase of the owner's structural fire insurance, though the owner may use a portion of gross rental proceeds obtained from all rental units in the community to purchase such structural fire insurance, and in such an event, that you are in no way a co-insured under any such policy.

9. **LOCKS AND LATCHES.** Keyed lock(s) will be rekeyed after the prior resident moves out. The rekeying will be done before you move in to your apartment. You agree to not install additional or different locks or latches on any doors or windows of the premises, unless we have consented in writing to such installation.

   You may at any time ask us to change or rekey locks or latches during the Lease Term. We must comply with those requests, but you must pay for them, unless otherwise provided by law.

   Payment for Rekeying, Repairs, Etc. You must pay for all repairs or replacements arising from misuse or damage to devices by you or your occupants, or guests during your occupancy. You may be required to pay in advance if we notify you within a reasonable time after your request that you are more than 30 days delinquent in reimbursing us for repairing or replacing a device which was misused or damaged by you, your guest or an occupant; or if you have requested that we repair or change or rekey the same device during the 30 days preceding your request and we have complied with your request. Otherwise, you must pay immediately after the work is completed.

Special Provisions and "What If" Clauses

10. **SPECIAL PROVISIONS.** The following special provisions and any addenda or written rules furnished to you at or before signing will become a part of this Lease Contract and will supersede any conflicting provisions of this printed Lease Contract form.

    See Additional Special Provisions

    See any additional special provisions.

11. **EARLY MOVE-OUT.** You'll be liable to us for a releting charge of $_____ (not to exceed 100% of the highest monthly rent during the Lease Contract term) if you:

    (1) fail to give written move-out notice as required in paragraphs 24 (Military Transfer and Lease Termination) or 46 (Move-Out Notice); or
    (2) move out without paying rent in full for the entire Lease Contract term or renewal period; or
    (3) move out at our demand because of your default; or
    (4) are judicially evicted.

    The releting charge is not a cancellation fee and does not release you from your obligations under this Lease Contract.

    Not a Release. The releting charge is not a Lease Contract cancellation fee or buyout fee. It is an agreed-to liquidated amount covering only part of our damages; that is, our time, effort, and expense in finding and processing a replacement resident. These damages are uncertain and difficult to ascertain—particularly those relating to inconvenience, paperwork, advertising, showing apartments, utilities for showing, checking prospects, office overhead, marketing costs, and locator-service fees. You agree that the releting charge is a reasonable estimate of such damages and that the charge is due whether or not our releting attempts succeed. If no amount is stipulated, you must pay our actual releting costs so far as they can be determined. The releting charge does not release you from continued liability for: future or past-due rent; charges for cleaning, repairing, repainting, or unreturned keys; or other sums due.

12. **REIMBURSEMENT.** You must promptly reimburse us for loss, damage, government fines, or cost of repairs or service in the apartment or apartment community due to a violation of the Lease Contract or rules, improper use, or negligence by you or your guests or occupants. Unless the damage or wastewater stoppage is due to our negligence, we're not liable for—and you must pay for—repairs, replacement costs, and damage to the following that result from your or your invitees, guests, or occupants' negligence or intentional acts: (1) damage to doors, windows, or screens; (2) damage from windows or doors left open; and (3) damage from wastewater stoppages caused by improper objects in lines exclusively serving your apartment. We may require payment at any time, including advance payment of repairs for which you're liable. Delay in demanding sums you owe is not a waiver.

13. **CONTRACTUAL LIEN AND PROPERTY LEFT IN APARTMENT. All property in the apartment is subject to a contractual lien to secure payment of delinquent rent.** For this purpose, "apartment" excludes common areas but includes interior living areas and exterior patios, balconies, attached garages, and storerooms for your exclusive use.

    Removal After Surrender, Abandonment, or Eviction. We or law officers may remove and/or store all property remaining in the apartment or in common areas (including any vehicles you or any occupant or guest owns or uses) if you are judicially evicted or if you surrender or abandon the apartment (see definitions in paragraph 51 - Deposit Return, Surrender, and Abandonment).

54. DISCLOSURE NOTICE. Name and address of the company or party authorized to manage the apartment community:
STYL Residential, 1 N Wacker Dr. Suite 2400, Chicago, IL 60606

Name and address of the company or party authorized to receive notices or lawsuits: STYL Residential, 1 N Wacker Dr. Suite 2400, Chicago, IL 60606

Management's corporate name and license number as required by the rules of the Georgia Real Estate Commission (Ga. R. & Reg. 520-1-.10 are _____

(Corporate Name of Licensed Managing Agent) and _____

(GREC corporate license number of Managing Agent).

You are legally bound by this document.
Read it carefully before signing.

Resident or Resident *(all sign below)*	**Date Signed**

Owner or Owner's Representative *(signing on behalf of owner)*	**Date Signed**

Name, address and phone number of managing agent for the property for notice purposes. This person or entity is authorized to receive services of process and to manage the property.
Porter Westside
820 West Marietta Street NW
Atlanta GA, 30318
(404)898-8720

Name and address of locator service *(if applicable)*

SPECIAL PROVISIONS (CONTINUED FROM PAGE 2) Prior to the execution of any residential lease, all prospects and residents must cooperate fully with the Pet Screening process. Each adult is required to complete a profile of their choosing (No Pet, Pet, or Assistance Animal) and the applicable process associated with the chosen profile. All profiles are to be renewed upon expiration without request by Management. Any resident found to have an incomplete or expired profile will be considered in violation of this lease and must immediately remedy the violation with the immediate processing of a new or renewed profile. If you indicated you did not have a pet, but acquired a pet during tenancy, you will be subject to our Pet Fees and Policies that are currently in place immediately upon notifying the leasing team or the pet being discovered. In addition, we are encouraging all residents to pay online. There is now a $25 fee to process each check/MO if you are otherwise able to pay online but elect to make a paper payment. Rentable item fees are not included in the lease contract. For Garage/Carport/Storage rent fees, please review the Enclosed Garage Addendum. Rentable item fees are not included in the lease contract.



Equal Housing Opportunity Provider

Disclosure of Information on Lead-Based Paint and/or Lead-Based Paint Hazards

Lead Warning Statement

Housing built before 1978 may contain lead-based paint. Lead from paint, paint chips, and dust can pose health hazards if not managed properly. Lead exposure is especially harmful to young children and pregnant women. Before renting pre-1978 housing, lessors must disclose the presence of known lead-based paint and/or lead-based paint hazards in the dwelling. Lessees must also receive a federally approved pamphlet on lead poisoning prevention.

Lessor's Disclosure

(a) Presence of lead-based paint and/or lead-based paint hazards (*check (i) or (ii) below*):

(i) ☐ Known lead-based paint and/or lead-based paint hazards are present in the housing (explain).

(ii) ☒ Lessor has no knowledge of lead-based paint and/or lead-based paint hazards in the housing.

(b) Records and reports available to the lessor (check (i) or (ii) below):

(i) ☐ Lessor has provided the lessee with all available records and reports pertaining to lead-based paint and/or lead-based paint hazards in the housing (list documents below).

(ii) ☒ Lessor has no reports or records pertaining to lead-based paint and/or lead-based paint hazards in the housing.

Lessee's Acknowledgement (*initial*)

(c) _____ Lessee has received copies of all information listed above.

(d) _____ Lessee has received the pamphlet Protect Your Family from Lead in Your Home.

Agent's Acknowledgement (*initial*)

(e) _____ Agent has informed the lessor of the lessor's obligations under 42 U.S.C. 4852d and is aware of his/her responsibility to ensure compliance.

Certification of Accuracy

The following parties have reviewed the information above and certify, to the best of their knowledge, that the information they have provided is true and accurate.

820 W Marietta Owner LLC, 820 West Marietta Street NW # 1475 #1475

Atlanta

Apartment Name & unit number OR street address of dwelling City

Lessee (Resident)	Date	Lessee (Resident)	Date
Lessee (Resident)	Date	Lessee (Resident)	Date
Lessee (Resident)	Date	Lessee (Resident)	Date

820 W Marietta Owner LLC

Lessor (Owner)	Agent
Date	Date

ADDENDUM TO LEASE

THIS ADDENDUM TO LEASE (this "Addendum") is dated as of 07/10/2025 (the "Effective Date"), by and between 820 W Marietta Owner LLC ("Owner"), and Katrina Highsmith ("Resident/s") for the purpose of amending that certain Lease Contract dated as of 07/15/2025 (the "Lease") by and between Owner and Resident for the premises commonly located at 820 West Marietta Street NW # 1475 #1475, Atlanta, GA 30318. In the event of a conflict between terms and provisions of this Addendum and the terms and provisions of the Lease or addendum thereto, the terms and provisions of this Addendum shall control. All capitalized terms use herein but not otherwise defined shall have the meanings ascribed to such terms in the Lease.

1. **Light Bulbs. Section 26** of the Lease is amended to reflect that Resident will be solely responsible for light bulbs relating to any fixtures Owner furnishes, including exterior fixtures operated from inside the apartment, and will replace all non-functioning or burnt-out light bulbs at their expense with bulbs of the recommended type and wattage for each such fixture. Owner will not supply light bulbs at any time and makes no representation as to the functionality or condition of any light bulbs at the time of Resident's move-in.

2. **Water Filters. Section 26** of the Lease is amended to reflect that Resident will be solely responsible for the replacement of any filters for water filtration systems that may be utilized in the Premises, including refrigerator water filters. Owner will not supply filters for water filtration systems at any time and makes no representation as to the functionality or condition of any filters for water filtration systems at the time of Resident's move-in.

3. **Paint Costs and Wall Repairs. Section 26** of the Lease is amended to reflect that Resident will be solely responsible for the costs of all painting and wall repairs performed in the Premises associated with nail holes larger than a pinhole or tack, adhesive strips, scuffs, scrapes, marks, dents, dings, and/or any other damages that exceed ordinary wear and tear.

4. **Counterparts, Electronic Signatures, Facsimile, PDF**. This Addendum may be executed in any number of identical counterparts, all of which, when taken together, shall constitute the same instrument. The parties acknowledge and consent to be bound by electronic signatures, including signatures of any required witness. A facsimile or .pdf copy of this instrument shall be deemed an original for all relevant purposes.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum as of the Effective Date.

OWNER:

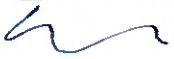
By: _____
Name: _____
Title: _____

RESIDENTS:

_____
_____
_____
_____
_____
_____

Document digitally signed using RentCafe eSignature services. Document ID: 1108238

The following information states that the identified document has been signed electronically by the parties detailed below:

Signee Details	Role	Signature	Initials	Date Signed
Katrina Highsmith	Resident			07/11/2025
Email ID: katrina.highsmith@gmail.com				
Site Manager	Manager			7/11/25

YOUR SOCIAL SECURITY CARD

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.



CHILD HEALTH RECORD:

FORM 1, GENERAL INFORMATION

CHILD'S NAME: Marquis Johnson **SEX:** M **BIRTHDATE:** 1/18/22

HEAD START CENTER: Kidazzle **PHONE:**

ADDRESS:

NAME OF INTERVIEWER: **TITLE:**

1. PERSON INTERVIEWED Katrina Highsmith-Johnson
   DATE 1/23/25 RELATIONSHIP TO CHILD Mother
2. CHILD'S NICKNAME, IF ANY MJ
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   820 West Marietta St UNH 1475
   Atlanta, GA 30318 Zip Code 30318
   PHONE 856-340-9600
4. FATHER'S NAME Marquis Johnson
5. MOTHER'S NAME Katrina Highsmith-Johnson
6. GUARDIAN'S NAME Katrina-Highsmith-Johnson
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   Kidazzle (Daycare)
   PHONE _____, RELATIONSHIP _____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   ✓ English _____ Spanish
   _____ Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES (NO) EPSDT/Medicaid (Latest certification No.):
   YES (NO) Federal, State or Local Agency:
   YES (NO) In-Kind Provider:
   YES (NO) Other (3rd party):
   ID NO.:
   YES (NO) WIC
   YES (NO) Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    February 2025
11. DATE OF LAST VISIT TO DENTIST
    August 2025

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE *(Name, address, and phone no.):*
    Physician Dr. Rogena Miller
    Clinic Wellstar Pediatrics in Smyrna
    Hospital ER
    Other
    Dentist Children's Dentistry

13. IN CASE OF EMERGENCY NOTIFY
    (1) Katrina Highsmith-Johnson
    Relationship Mother
    Phone 856-340-9600 or 678-373-9279
    (2) Marquis Johnson
    Relationship Father
    Phone _____ or _____
    (3) Denise Highsmith
    Relationship Grandmother
    Phone 856-889-9077 or _____

14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites N/A
    - ☐ Allergy, Medication
    - ☐ Other

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER Marquis Johnson	5/18	✓		ADD
MOTHER Katrina Highsmith-Johnson	4/25	✓		Asthma, Migranes (Sometimes)
BROTHERS & SISTERS *(oldest first)*				
(1) Phoenix Jones			✓	
(2) Kayden Johnson		✓		
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

INTERVIEWER: GO TO FORM 2A

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

CHILD HEALTH RECORD:

FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:

CHILD'S NAME: Margui'S Johnson SEX: M BIRTHDATE: 1/18/22

PERSON INTERVIEWED: Katrina Highsmith-Johnson DATE: 2/23/22 RELATIONSHIP: Mother

NAME OF INTERVIEWER: _____ TITLE: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?		✓	
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?		✓	
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?		✓	
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?		✓	
5. WHAT WAS CHILD'S BIRTH WEIGHT?			6 lbs., 8 oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?		✓	
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?		✓	
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?		✓	
9. IS MOTHER PREGNANT NOW?		✓	*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?	✓		Dehydration
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?		✓	
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?		✓	

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ____SORE THROAT; ____COUGH, ____URINARY INFECTIONS OR TROUBLE URINATING, ____STOMACH PAIN, VOMITING, DIARRHEA?		✓	
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)*?	*	✓	
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?		✓	*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)*?	*	✓	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?		✓	
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*	✓	*If "yes" ask:* WHEN DID IT LAST HAPPEN?_____ WHAT MEDICINE?_____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*		✓	WHAT MEDICINE?_____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START?_____HOW OFTEN?_____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME: Dr. Regina Miller)
21. HAS CHILD HAD: ____BOILS, ____CHICKENPOX, ____ECZEMA, ____GERMAN MEASLES, ____MEASLES, ____MUMPS, ____SCARLET FEVER, ____WHOOPING COUGH?		✓	
22. HAS CHILD HAD: ____HIVES, ____POLIO?	*	✓	
23. HAS CHILD HAD: ____ASTHMA, ____BLEEDING TENDENCIES ____DIABETES, ____EPILEPSY, ____HEART/BLOOD VESSEL DISEASE, ____LIVER DISEASE, ____RHEUMATIC FEVER, ____SICKLE CELL DISEASE?	*	✓	*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)*? a WHEN EATING ANY FOODS? N/A b WHEN TAKING ANY MEDICATION? N/A c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? N/A	*	✓	*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?		✓	DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?		✓	DESCRIBE: WHEN?

* *If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: Katrina Highsmith Johnson **DATE:** 1/23/26 **RELATIONSHIP:** mom

NAME OF INTERVIEWER: _____ **TITLE:** _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?
Animals, Science and Building

28. DOES YOUR CHILD TAKE A NAP? ____NO, ✓YES. IF "YES" DESCRIBE WHEN AND HOW LONG.
Sometimes. Depends on the day 1-2 hrs.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? ____NO, ✓YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH). He is a night owl like his father. He does like to sleep w/ us.

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? He goes on his own, unless we are in the

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? ✓NO, ____YES. IF "YES" PLEASE DESCRIBE. _____

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?
Funny! If he doesn't know someone or comfortable, he will communicate it.

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE? Plays well.

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?
Sometimes has a hard time sharing. Other than that will play well.

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ✓NO, ____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO Walk EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO 11 mos ?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP		✓		
(b) CRAWL		✓		
(c) WALK	✓			
(d) TALK		✓		
(e) FEED AND DRESS SELF		✓		
(f) LEARN TO USE THE TOILET		✓		
(g) RESPOND TO DIRECTIONS		✓		
(h) PLAY WITH TOYS		✓		
(i) USE CRAYONS		✓		
(j) UNDERSTAND WHAT IS SAID TO HIM/HER		✓		

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? ✓NO, ____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? ✓NO, ____YES. IF "YES" CAN YOU TELL ME ABOUT THAT? If this does occur, I remind him to use his words to tell me what is going on.

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? ✓NO, ____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? ____NO, ✓YES. IF "YES" PLEASE DESCRIBE. We may move. Looking to purchase a house soon.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? ____NO, ____YES. IF "YES" PLEASE DESCRIBE?
He is active and likes to experience learning through interactive activities. Through dance, songs, games, etc.

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

YMCA OF METRO ATLANTA

EARLY LEARNING

CONSENT FOR EMERGENCY MEDICAL OR DENTAL TREATMENT

I, Katrina Highsmith-Johnson, hereby give my consent for emergency medical or
(Parent/Guardian)

dental treatment services for my child Marquis Johnson.
(Child's Name)

I consent for my child to be transported to and from the source of emergency treatment. I understand that this care may include examinations and any test which, in the opinion of the attending health care provider or dentist, deems necessary.

I agree that if my child incurs a deep laceration that may require sutures, or first aid services, I give my permission for this treatment to be provided by a qualified medical professional. **However, this does not give consent to perform surgical procedures without further informed consent from me.**

I have provided my child's school with emergency contact information (telephone numbers) that may be used to contact me or a designee in the event of a medical emergency.

First Year:	Katrina Highsmith-Johnson **Parent Signature**	1/16/26 **Date**
First Year:	**Staff Signature**	8/3/24 **Date**
Second Year:	**Parent Signature**	**Date**
Second Year:	**Staff Signature**	**Date**
Third Year:	**Parent Signature**	**Date**
Third Year:	**Staff Signature**	**Date**

YMCA OF METRO ATLANTA

EARLY LEARNING

PERMISSION TO PERFORM SCREENINGS & EXAMINATIONS

I, Katerra Highsmith-Johnson, hereby give my consent for Marquis Johnson

(Parent Guardian) (Child's Name)

To receive the indicated screenings, assessments and examinations listed below. I understand that the YMCA of Metro Atlanta Early Learning, in accordance with the Performance Standard, deems these services a requirement and necessary. I also understand that the Early Learning Program may provide the services directly or by Certified Contract Providers designated by the program and that I will be informed of any abnormal results.

I understand that if I provide the YMCA of Metro Atlanta Early Learning Program with documentation of any of the applicable screening(s) or examinations listed below it may not be necessary to utilize this consent form for services.

I understand that by giving consent for a physical exam, I am giving the YMCA of Metro Atlanta Early Learning program permission to perform the exam with my child suitably draped, in accordance with the American Academy of Pediatrics (AAP).

I give the YMCA of Metro Atlanta Early Learning Program permission to perform *required* exams and/or screenings.

	Yes	No		Yes	No
Physical Exam	☑	☐	Hearing Screening	☑	☐
Blood Pressure Reading	☑	☐	Vision Screening	☑	☐
Hemoglobin	☑	☐	Developmental Screening	☑	☐
Lead Screening	☑	☐	Behavioral Screening	☑	☐
Height / Weight Measurements	☑	☐	Speech Screening	☑	☐

Katerra Highsmith-Johnson — 1/16/26

Signature of Parent/Legal Guardian — Date

K. Hines — 8/8/24

Family Services Assistant — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

DENTAL SERVICES IDENTIFICATION FORM

Child's Name: Marquis Johnson Parent/Legal Guardian: Katrina Hayhurst Johnson

I understand that the YMCA of Metro Atlanta Early Learning Program requires a complete dental examination within (90) days of enrollment.

I also understand that if my child does not have a dental examination the Early Learning Program has contracted with licensed providers who may render these services to my child. I also agree to submit all required documentation (i.e. Medicaid card, Peach Care card, etc., if applicable) to the Family Services Assistant before my child's appointment.

I hereby give my permission to have ~~Marquis Johnson~~ (Child's Name) examined by a licensed dentist contracted with the YMCA of Metro Atlanta Early Learning Program. I understand that the examinations may contain the following services:

Examination by a Licensed Dentist	X
Dental X-rays	X
Prophylaxis (teeth cleaned)	X

I further understand that I will be notified of the results of the dental examination and that I will be informed in writing if further follow-up treatment is required.

Parent/Legal Guardian Signature — Date

Staff Signature — Date

OR

I HEREBY DECLINE FOR MY CHILD TO BE EXAMINED BY AN AGENCY CONTRACTED DENTIST. I understand that it is a requirement of The YMCA of Early Learning to have a complete dental examination and, therefore, I will accept the responsibility for my child receiving a dental exam. I will ensure that the YMCA of Early Learning receives a copy of my child's current dental exam results.

Katrina Hayhurst Johnson — Parent/Legal Guardian Signature — Date: 1/16/26

Staff Signature — Date: 8/3/24

Revised June 2025

YMCA OF METRO ATLANTA

EARLY LEARNING

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization:
With the exception 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 parent.

I give Kidazzle (Name of Facility), permission to apply one or more of the following topical ointments/preparations to Marquis Johnson (Child's name) in K5 Room (Classroom) in accordance with the directions on the label of the container.

- ✓ Baby Wipes
- ✓ Band-aids
- ✓ Neosporin or similar ointment
- ✓ Bactine or similar first aid spray
- ✓ Sunscreen
- ✓ Insect Repellent
- ✓ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
- ____ Baby Powder

Other (please specify) _____

Katrina Hayworth-Johnson — Parent/Guardian Signature

1/14/26 — Date

*Center should maintain in Daily Health Check notebook.

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

JOHNSON JR, MARQUIS ADRIAN
Child's Name (Last name, First name)

01 | 18 | 2022
Birthdate

HIGHSMITH, KATRINA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2034
Date of Expiration
(Next required immunization or review of medical exemption due.)

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	03 30 22	05 18 22	08 05 22	04 19 23	02 06 26		5				
Polio	03 30 22	05 18 22	08 05 22	02 06 26			4				
Hepatitis B	03 30 22	05 18 22	08 05 22				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	03 30 22	05 18 22	04 19 23				3				
PCV (Under Age 5)	03 30 22	05 18 22	08 05 22	04 19 23			4				
Measles	01 20 23	02 06 26					2				
Mumps	01 20 23	02 06 26					2				
Rubella	01 20 23	02 06 26					2				
Hepatitis A (Born on/after 1/1/06)	01 20 23	07 26 23					2				
Varicella	01 20 23	02 06 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	03 30 22	05 18 22	08 05 22				3				
HPV							0				
Influenza	11 09 22	12 14 22	01 24 24	02 06 26			4				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Rogena Miller MD
562 Concord Rd SE
770-384-9830
Smyrna, GA 30082

Dr. Rogena Miller
562 Concord Road, SE
Smyrna, GA 30082
Phone: 770-384-9830
Fax: 770-384-9835

RMR
2/6/2020

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

JOHNSON JR, MARQUIS ADRIAN
Child's Name (Last name, First name)

01 | 18 | 2022
Birthdate

HIGHSMITH, KATRINA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

[ ] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	03 30 22	05 18 22	08 05 22	04 19 23			4				
Polio	03 30 22	05 18 22	08 05 22				3				
Hepatitis B	03 30 22	05 18 22	08 05 22				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	03 30 22	05 18 22	04 19 23				3				
PCV (Under Age 5)	03 30 22	05 18 22	08 05 22	04 19 23			4				
Measles	01 20 23						1				
Mumps	01 20 23						1				
Rubella	01 20 23						1				
Hepatitis A (Born on/after 1/1/06)	01 20 23	07 26 23					2				
Varicella	01 20 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus	03 30 22	05 18 22	08 05 22				3				
HPV							0				
Influenza	11 09 22	12 14 22	01 24 24				3				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Primary Care Center Peds Smyrna
562 Concord Rd SE
Smyrna, GA 30082

1/12/24

Georgia Department of Public Health
Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/ Guardian Name: Katerina (first) Highsmith-Johnson (middle/last)

Parent/ Guardian Contact Information:
Daytime phone number: 856-340-9600
Evening phone number: "
Cell phone number: "

Child's Name: Marquis (first) A (middle) Johnson, Jr. (last)

Date of Birth: 01/18/2022 **Gender:** ☒ Male ☐ Female

Child's Home Address: 820 W. Marietta St. Unit 1475 ATL GA 30318 Fulton
(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

M. Pharr, LPN 02/16/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:
Dr. Rogena Miller
562 Concord Road, SE
Smyrna, GA 30082
770-384-9830 Phone
770-384-9835 Fax

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

M. Pharr, LPN 02/16/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:
Dr. Rogena Miller
562 Concord Road, SE
Smyrna, GA 30082
770-384-9830 Phone
770-384-9835 Fax

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: 42.21" Weight: 41 lb 9.6 oz
BMI: 16.42 kg/m² BMI%: 75%

- ☒ 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

M. Pharr, LPN 02/16/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:
Dr. Rogena Miller
562 Concord Road, SE
Smyrna, GA 30082
770-384-9830 Phone
770-384-9835 Fax

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

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

Referral initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

DPH
GEORGIA DEPARTMENT OF PUBLIC HEALTH

Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/ Guardian Name: ____ first ____ middle ____ last

Parent/ Guardian Contact Information:
Daytime phone number: ____
Evening phone number: ____
Cell phone number: ____

Child's Name: marquis (first) johnson (middle) ____ (last)
Date of Birth: 01/18/2022 **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

08/25/25
Susan H. Lee, DMD
Screener's Signature ____ Date ____
I certify that this child has received the above screening.
Contact Information:
Susan H. Lee, DMD
Children's Dentistry
3280 Howell Mill Rd, NW
Suite 121
Atlanta, GA 30327

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: ____

DPH Form 3300 Rev. 2020

DPH
GEORGIA DEPARTMENT OF PUBLIC HEALTH

Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/ Guardian Name: _____ (first / middle / last)

Parent/ Guardian Contact Information:

Daytime phone number: _____

Evening phone number: _____

Cell phone number: _____

Child's Name: marquis (first) johnson (middle) _____ (last)

Date of Birth: 01 / 18 / 2022 **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

08/25/25
Susan H. Lee DMD
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

Susan H. Lee, DMD
Children's Dentistry
3280 Howell Mill Rd, NW
Suite 121
Atlanta, GA 30327

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: _____

DPH Form 3300 Rev. 2020

YMCA OF METRO ATLANTA
EARLY LEARNING

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CHILD'S NAME	DATE OF BIRTH	ADDRESS
Marquis Johnson	1/8/22	880 N. Marietta St NW Unit 1475 Atlanta, GA 30318

I, Katrina Highsmith-Johnson (Parent/Guardian), authorize the use or disclosure of the above-named individual's health information as described below.

1. The following individual or organization is authorized to make disclosure:
   Name/Organization: _____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   - Immunization record
   - Medication information
   - List of allergies
   - Most recent dental exam from _____
   - Most recent Health history and physical exam from _____
   - Nutrition Records (WIC, Assessments) from _____
   - Approval of returning to school
   - Specified lab results (Hemoglobin, Hematocrit, Lead or TB screening only)
   - Early Intervention record (Babies Can't Wait Program) _____
   - Disabilities records from _____
   - Medicaid, Peach Care or insurance eligibility _____
   - Other Specific Information must be written below _____

3. I understand that the information in my child's health record may include information related to my child's overall health status. It may also include information about behavioral or mental health services and other treatment.

4. The information may be disclosed to and used by the following individual or organization:

   Name: **YMCA of Metro Atlanta EARLY LEARNING** _____

   Address: _____ Telephone _____ Fax: _____

   For the purpose of _____

5. I understand that I have a right to revoke the authorization at any time. I understand that if I revoke this authorization I must do in writing. I understand that the revocation may not apply to information I have already disclosed or released prior to this authorization.

6. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure emergency medical treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal Confidentiality Rules.

Signature of Parent or Legal Guardian: Katrina Highsmith-Johnson Date: 1/25/26

Signature of Early Learning Staff: _____ Date: 8/13/26

WHITEFOOD

PEDIATRIC CONSENT FORM

understand that Whitefoord Inc. Health Centers and School Based Health Centers can provide comprehensive health services to my child. I also nderstand that I have the right to withdraw this consent at any time upon written notice to the medical director.

authorize (**check all services for which you consent**):

☑ Release of information from the child's medical record whenever necessary for payment, continued care or treatment, and ealthcare operations.

☑ I further give consent for staff to examine the child's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.

☑ For my child to receive medical care including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease anagement, referrals, and other minor office procedures.

☐ Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian

☑ For my child to receive dental care. This includes periodic dental examinations for my child, which may include screenings, hotographs, radiographs and any other acceptable methods for the dental evaluation and management of the child's dental health.

☑ For my child to receive behavioral health and counseling services, including one-on-one counseling, community resource referrals nd outreach and coordination of outside resources.

☑ Participation in health education sponsored/coordinated by Whitefoord Inc. (including, but not limited to: nutrition, sexual health, ealth and wellness, etc.

☑ That in the case of a medical emergency, I give permission to Whitefoord Health Centers to call emergency transport for my child.

n order for health center staff members to provide services, I authorize the school to release school records on a "need to know" basis to the Whitefoord Health and School Based Health Center staff members, and also for Whitefoord Health Center staff members to release medical ecords to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may nclude the following: immunization records, class schedules, parental contact, address, phone number, medical/behavioral health conditions, ealth screenings, medications, health care plans, or attendance information. The medical and mental health providers from Whitefoord Health Centers may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed elow to release information to the Health Center staff members as needed. I hereby authorize the Health Center to provide the services as ndicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served egardless of the ability to pay. I hereby authorize Whitefoord Health Center staff members to release any medical records required by the nsurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, Health Center staff members will use nd share my Personal Health Information (PHI) for: treatment of my child's health condition, maintaining the continuity of my child's care and ayment for health services provided to my child, and routine health care operations including quality improvement, accreditation, educational urposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the ocation(s) my child receives his/her health care services.

have read and understand the above information and give permission for the child's care as described. I understand that I have the right to pt the child out of any medical testing or treatment. This consent will last for three years or the duration of the child's time at their current chool housing a Whitefoord School Based Health Center location.

Name of Parent or Legal Guardian (please print): Katrina Highsmith-Johnson	Name of Child (please print): Marquis Johnson
Signature of Parent or Legal Guardian: Katrina Highsmith Johnson	Relationship to Child: Mother Date: 1/16/26

Rev. Aug, 2021

WHITEFOORD

LEASE WRITE CLEARLY

chool Based Health Center Consent

School: Kidazzle
Grade: Pre K - 4
Homeroom Teacher:

'ATIENT INFORMATION

Name: Marquis Johnson **Date of Birth:** 1/18/22
Address: 820 West Marietta St. NW Unit 1475
Home Phone: 856-340-9600 **Email address:** katrina.highsmithe gmail.com
Cell
'arent (please circle) Mom Dad Other:
Child lives with (please circle) Mom Dad Other:
Emergency Contact: Katrina Highsmith-Johnson
Phone: 856-340-9600 Cell Landline (please circle)
f unavailable, can Whitefoord discuss your child's personal health information with anyone else?
Name & Relationship to child: Marquis Johnson - father
Phone Number: 602-820-0508

nsurance Information:

nsurance carrier name: NaltheZ
D/Member Number: 695834822 Group Number: IADA740
'olicy Holder & Date of Birth: Katrina Highsmith-Johnson 5/25/87

The following is required because we receive Federal funding for providing services at a discount. This information is for tatistical purposes and will not be disclosed.

Total household income:
Please circle: Hourly Weekly Monthly Yearly
Number of people in the household: 4
f there is no insurance coverage, would you be interested in discounts based on a sliding scale? Yes No
Would you like someone to contact you about applying for the discount? Yes No
Services requested (please circle): Medical Dental Counseling or Behavioral Health Services
Patient Gender Identity (please circle): Male Female
Patient Race (please circle): American Indian - Alaskan Native - Asian - Native American – Black - White
Ethnicity (please circle): Hispanic/Latino - Not Hispanic/Latino - Unknown

Patient Medical History:

Allergies: N/A
Please list any surgeries:

Medical conditions:

Please circle answer
Asthma: Yes No
Diabetes Yes No
Other Yes No **Please explain if yes:**
Recent ER Visit (please circle): Yes No
If yes, please explain:
Reason for Visit:
Facility:
Current Medications: N/A
Please include doses, mgs, and how often taken
Do you have another Primary Care Provider? Yes No
Provider's Name: Wellstar - Dr. Rozana Miller
Provider's Phone Number: 770-384-9830

Parent Signature: Katrina Highsmith-Johnson **Date:** 1/16/26

Rev. Aug, 2021

SCHOOL-BASED HEALTH CENTER PATIENT CONSENT FORM

The Family Health Centers of Georgia, Inc.

School District **Date:** 1/23/26

[ ] Clayton [ ] Douglas [✓] Fulton: College Park or Lake Forest (circle one) [ ] Banneker

You must complete all information **USING INK, SIGN & DATE** in order for your child to receive healthcare services from the Health Center. It is your responsibility to notify us immediately of any changes in address, phone number or insurance.

PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name: ~~Kafim~~ Marquis (first) A (middle initial) Johnson (last)

Patient's Address: 820 W. Marietta St. NW (street)

City: Atlanta State: GA Zip Code: 30318

Patient's Social Security #: _____ Date of Birth: 1/18/22 Sex: M

Birth Country: [✓] USA [ ] Other _____ Primary Language: [✓] English [ ] Other _____

School: Kidazzle Childcare

Grade: Pre K-4 Remedial/Special Education [ ] Yes [✓] No

Contact #: Home #: _____ Cell #: [redacted]

Work #: 1-877-410-1002 Other #: _____

Parent/Guardian's Email: Katrina.Highsmith@gmail.com

Emergency Contact Name: Katerina Highsmith-Johnson Relationship to Patient: Mother

Emergency Contact #: Home #: _____ Cell #: 856-340-9100

Work #: _____ Other #: 678-373-9279

INSURANCE INFORMATION

[ ] No Insurance [ ] Medicaid #: _____ [✓] Private Insurance

Please indicate insurance company's name for private insurance: Health EZ

Member's Name (as listed on insurance card): Katerina Highsmith Policy #: 695834222

Group #: TADA740 Address: Cigna PO Box 188061

Your child may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? [ ] Yes [ ] No

HEALTH INFORMATION

Medical Conditions (physical, behavioral health, dental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Allergies (medications, food, environmental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Dental Appointment in the past year: [ ] Yes [ ] No

PATIENT DEMOGRAPHICS

Special Populations (Check all that apply.)

[ ] Migrant Agricultural Worker/Farmer
[ ] Public Housing (live in or access to)
[ ] Seasonal Agricultural Worker/Farmer
[ ] Veteran
[ ] None of the above
[ ] Choose not to disclose

Housing (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] Public Housing (live in or access to)
[ ] Shelter
[ ] Street (car, outdoors, makeshift housing)
[ ] Transitional Housing
[ ] None of the above
[ ] Choose not to disclose

SELF REPORTED INCOME

Number of people living in household: 4 Household Income: _____ [ ] Choose not to Disclose

I hereby give consent for my child to continue to receive medical, behavioral and dental services (when available) from The Family Health Centers of Georgia's School-Based Health Center. I authorize any physicial-designated health professional, dentist or behavioral health provider working for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

Katrina Highsmith-Johnson
Name of Parent or Legal Guardian (please print)

Katrina Highsmith-Johnson Marquis Johnson
Name of Patient (please print)

X _____
Signature of Parent or Legal Guardian

Mother
Relationship to Patient

Date: 1/25/26

School Parental/Guardian Consent and Release

STEP 1

Name of Child: Harquis Johnson Child Age: 4

School Name: Kidazzle

City: Atlanta State: GA Zip: 30318

Email: Katrina.Highsmithequail.com Phone: 856-340-9600

In each step below, please read and check one box only. Once Steps 2-4 are completed, please sign at Step 5.

STEP 2: Dental Screening

YES ☑ NO ☐

Your Child is being offered a **FREE DENTAL SCREENING** as part of the Bright Smiles, Bright Futures (BSBF) program sponsored by Colgate-Palmolive Company ("Colgate"). By checking the "**YES**" box in Step 2, you are stating that you understand and agree that:

Colgate is providing the dental screening as a public service and your Child is participating in the BSBF dental screening voluntarily and at their and your own risk;

You are releasing and discharging Colgate and anyone affiliated with Colgate, including, without limitation, the volunteer dental professionals who are conducting the screenings, from any and all liabilities, suits, costs, or expenses in any way relating to the participation of the Child in the BSBF dental screening program; and

This Release is governed by New York law and that no changes to this Consent and Release are valid unless executed in writing by both you and Colgate.

STEP 3: Release of Protected Health Information

YES ☑ NO ☐

I understand that by checking "**Yes**" and signing this form, I authorize the dentist, dental specialist, or health care provider/entity conducting the BSBF program dental screening to use and disclose my child's protected health information, either in electronic or hardcopy form, to (i) another dentist, dental specialist, or health care provider/entity for treatment purposes, (ii) his or her school or employees of the school (such as teachers or medical staff) for informational, record keeping, or reporting purposes, or (iii) Colgate for informational, record keeping, or reporting purposes.

I understand that signing this authorization is voluntary. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that this authorization is valid until revoked. I understand I have the right to revoke this authorization at any time by sending written notification to Colgate-Palmolive Company, 300 Park Avenue, NY, NY 10022, Attn: Bright Smiles, Bright Futures. I understand that a revocation is not effective to the extent that any entity has already relied on this authorization to use or disclose my child's health information as described above.

STEP 4: Photo Release

YES ☑ NO ☐

Read and complete Step 4 regardless of whether your Child is participating in the BSBF dental screening program described in Step 2:

We may be taking photos and/or video of your Child at the BSBF program. By checking the "**YES**" box in Step 4, you are agreeing that:

Colgate and its BSBF partners, and anyone affiliated with Colgate or its BSBF partners (the "Colgate and BSBF Partners"), can use the photos and/or videos taken of your Child at the BSBF program in any and all media worldwide for as long as they wish to do so, including in external-facing media such as websites, social media, or brochures. The photos and/or videos taken of your Child will only be used to promote, publicize, or describe the BSBF program or Colgate's and/or its BSBF partners' community service or social responsibility efforts.

The Colgate and BSBF Partners can edit photos and/or videos taken of your Child without prior approval by you, and that Colgate is the owner of any and all photos and/or videos taken of your Child at the BSBF program; and

You are releasing and agreeing to hold harmless Colgate and its BSBF partners from any and all liability resulting from the use of any photos and/or videos taken of your Child at the BSBF event, and that this Consent and Release is governed by New York law.

STEP 5

Parent or Legal Guardian (Print name): Katrina Highsmith-Johnson

Signature (of Parent or Legal Guardian): Katrina Highsmith-Johnson

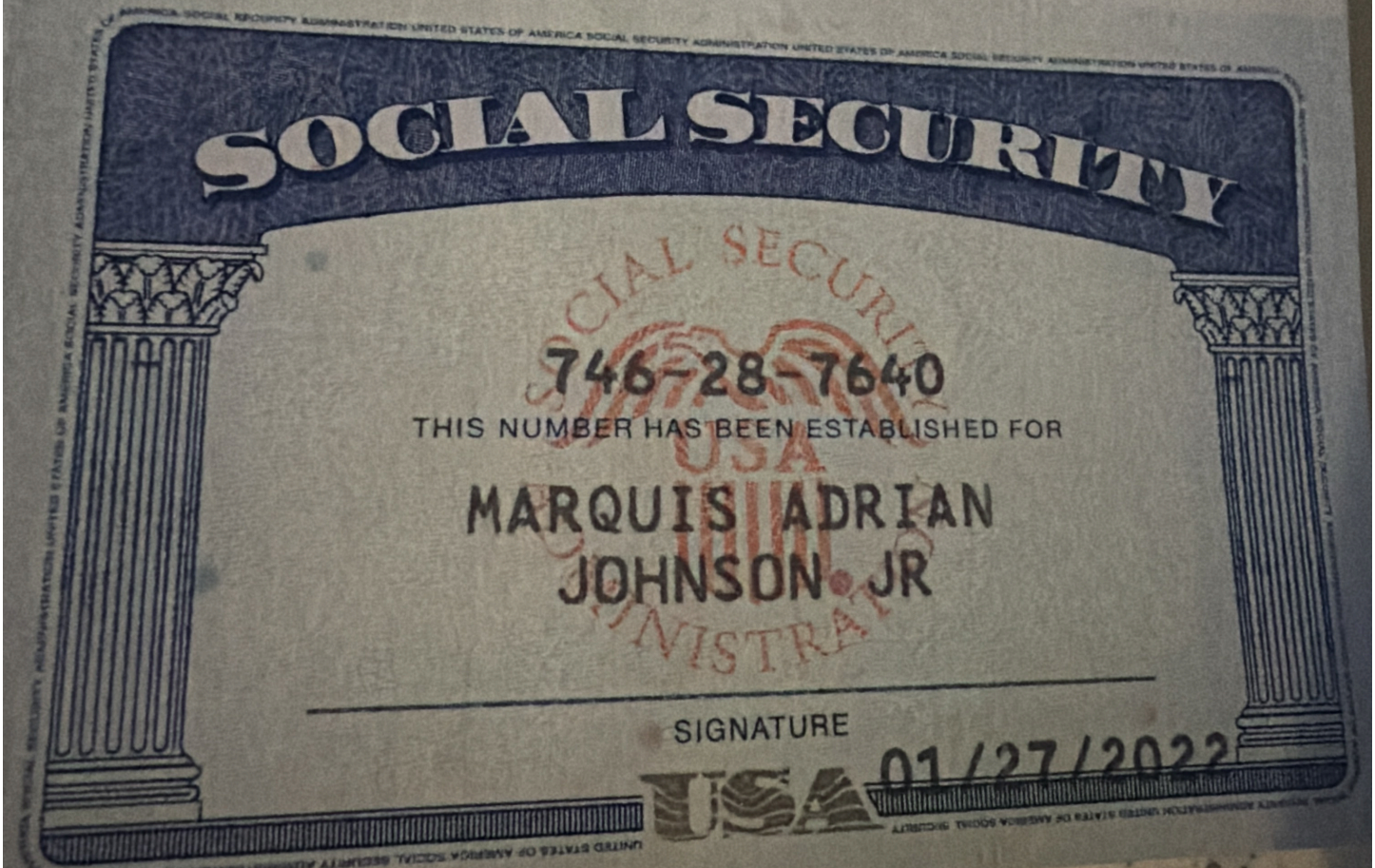
Date: 1/25/26

REMINDER! Please make sure you check either Yes or No in steps 2, 3 and 4.

YOUR SOCIAL SECURITY CARD

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.



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

Child's Name (First, Middle, Last): Marquis Johnson

Date of Birth: 01/18/22 **Gender:** ☒ Male ☐ Female

Home Address: _____
Street City State Zip Code

Parent/Guardian Name (First, Middle, Last): _____

Parent/Guardian Contact Information:

Primary Phone#: _____ Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☐ **Distance visual acuity chart** (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ **Instrument-based/Photoscreener** (**Alternative method; see guidance below)

Results:
☐ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☐ **Pure tone audiometry** (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ **Automated Otoacoustic Emissions** (**Alternative method; see guidance below)

Results:
☐ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

DENTAL

Results:
☒ Normal appearance 09/14/26
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☒ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

Susan H. Lee DMD

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

Susan H. Lee, DMD
Children's Dentistry
3280 Howell Mill Rd, NW
Suite 121
Atlanta, GA 30327

NUTRITION

Results:
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 in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

Vision and Hearing Screening Method Guidance:
* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Jones, Ava Raye	**State Student ID:** 2609531
Date of Birth: 01/01/22	**Classroom:** Room 7
Parent / Guardian: Keely Scott	**Contact Phone:** 404-964-3318

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (8 PENDING)

Remaining items needed for 100% compliance: **Child Certified Birth Certificate; Proof of GA Residency; Child Physical SSN Card; Form 3231 (Immunization Certificate); Form 3300 (Screening Certificate); Parent Photo ID; Signed Appendix D Roster Form; CACFP Income Statement**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Jones_Ava_Raye.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Ava_Jones.pdf	1	✓ SIGNED
3	**Registration Application**	[Untitled]_085488.pdf	6	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609531
Student Name: Jones, Ava Raye	**Date of Birth:** 01/01/22
Parent(s)/Guardian: Keely Scott	**Phone:** 404-964-3318

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
[ACTION NEEDED]	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
[ACTION NEEDED]	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
[ACTION NEEDED]	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
[ACTION NEEDED]	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
[ACTION NEEDED]	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609531

Scan the QR code or click the link above. Use child's Date of Birth (**01/01/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Jones, Ava Raye** Parent Signature: _____ Date: _____

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Ava
Legal Middle Name: Raye
Legal Last Name: Jones
Name Suffix (Jr,II,III):
Name Child is Called:
Child's Social Security: 117-73-0591
Date of Birth: 01/01/2022
Gender: M [ ] F [X]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Scott
First Name: Keely
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: keelyscott88@gmail.com
Zip Code: 30317

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

Parent/Guardian Signature

2026-07-31

Date

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box → 2026-27

Pre-K Registration Form School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDAZZLE - SUMMIT

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Jones			
CHILD'S FIRST NAME: Ava			
CHILD'S MIDDLE NAME: Raye	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 117730591	D.O.B. (MM/DD/BY): 2022-01-1	SEX:	☐M ☑F
HOME ADDRESS (*Do not enter PO Box Info*): 1155 Windsor street sw		COUNTY:	
CITY: Atlanta	STATE: GA ZIP: 30310	HOME PHONE:	(706)376225

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: Scott	FIRST: Keely	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.	Keely Scott	Mom	4706376225		Keely.scott09@gmai
2.					l.com

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.

Keely Scott

Signature Parent/Guardian: Keely Scott **DATE:** 2026-07-31

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.

Keely Scott

SIGNATURE (Parent/Guardian): Keely Scott

DATE: 2026-07-31

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, Ava Jones, 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 Keely Scott

SIGNATURE (Parent/Guardian): Keely Scott

DATE: 2026-07-31

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-07-31 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Ava Jones

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑**Breakfast** ☑**Lunch** ☑**Afternoon Snack** ☑**Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Keely Scott

Parent/Guardian Signature: Keely Scott

Date: 2026-07-31

Facility Administrator Signature: _____

Date: 8/3/24

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-07-31

CHILD INFORMATION:

Legal First Name: Ava

Name Suffix (Jr,II,III):

Legal Middle Name: Raye

Name Child is Called:

Legal Last Name: Jones

Child's Social Security # 117730591

DOB (M/D/Y): 2022-01-12

Gender: M F

Choose Not to Provide SSN

Date enrolled in Pre-K (M/D/Y):

PARENT/GUARDIAN INFORMATION:

Last Name:

First Name:

Relationship: Mother Father Grandparent Guardian Other

Email Address:

Zip Code:

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

f. **Decline to Answer**

3. What is your child's primary language?

English

A language other than English

3.a. Which language is spoken in the child's home (other than English)?

4. Was your child born as a:

Single Birth (1)

Twin (2)

Triplet (3)

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

Yes **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)

6. Does your child receive any of the following services?

Childcare and Parent Services (CAPS)

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

Supplemental Nutrition Assistance Program (SNAP)

Medicaid

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

Yes **No**

Keely Scott

Parent/Guardian Signature

2026-07-31

Date

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Lahori, Yasir Jahmal	**State Student ID:** 2609521
Date of Birth: 04/29/22	**Classroom:** Room 7
Parent / Guardian: Dashay Marie Brown	**Contact Phone:** 404-610-4491

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Lahori_Yasir.pdf	1	✓ OFFICIAL
2	**CACFP IES Enrollment**	IES_form_2025_2026_Summit_-_Template_-_Template (7).pdf	11	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	Yasir_Lahori_Dental_3300.pdf	1	✓ VERIFIED
4	**ChildPlus Head Start Enrollment & Family Partnership Agreement**	CamScanner 10-22-2026 17.06.pdf	6	✓ VERIFIED
5	**Head Start Physical Exam (Form #78)**	Lahori, Yasir Jahmal - Head Start Physical Exam.pdf	1	✓ VERIFIED
6	**Form 3300 (Screening Certificate)**	Lahori, Yasir Jahmal - Form 3300 Screening Certificate.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Date: September 15, 2026	**Classroom:** Room 7 (Site ID: 33915)
Student Name: Lahori, Yasir	**Date of Birth:** 04/28/2022
Parent(s)/Guardian: Dashay (Jane) Brown	**Phone:** 404-610-4491

Dear Parent/Guardian,

Under **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all students attending Georgia's Pre-K Program must have complete, state-mandated documentation on file at the center. During our compliance and data collection audit, the documentation below was identified as missing or incomplete for your child.

ACTION REQUIRED — OUTSTANDING ITEMS NEEDED:

- **Form 3300 (Ear, Eye, Dental Screening)**

Important Guidelines for Required Documents:

- **Form 3300 (Screening):** Must include all four components (Ear/Hearing, Eye/Vision, Dental, and Nutrition). Blood pressure and lead screening must be recorded.
- **Form 3231 (Immunizations):** Must be a current Georgia Certificate of Immunization with valid expiration date or marked 'Complete for School'.
- **Proof of Residence:** Current gas, electric, or water utility bill (dated within 30 days) or valid lease agreement showing matching home address.
- **Social Security / 30-Day Waiver:** If an official 30-day waiver was signed, the physical card or proof of card order from SSA must be presented before the grace period expires.

COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please submit clear, readable copies immediately to ensure your child's enrollment remains in active standing with Georgia DECAL.

- **Email Submissions:** Send scanned copies or clear photos directly to **Ms. Karen Harris** at: karenharris@kidazzle.com
- **In-Person Submissions:** Hand-deliver original documents or copies to the Administrative Front Desk.
- **Questions / Support:** Call Ms. Harris at **(404) 753-8884** or mobile at **(404) 884-1483**.

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Lahori, Yasir** Parent Signature: _____ Date: _____

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Lahori Yasir	SNAP, TANF	☑	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
Last Name First Name		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

Child Income/How often? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Yasir Lahori	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
2. East Lahori	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. jDashay Brown	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4.	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5.	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX 5426 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunda☑ Monday☑ uesda☑ Wednesda☑ Thursda☑ Friday Saturday

Circle the meals your child will normally receive while in care☑ reakfast AM Snack☑ Lunch☑ PM Snack Supper Evening Snack

PART IV: Signature
*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category.***

Dashay Brown

Signature: X _____ **Print Name:** Dashay Brown **Date:** 2026-08-03

Address: 760 Old Dive Ln **City:** Atlanta **State:** _____ **Zip:** GA **Phone:** 404 977 6780

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ anic/ Latino Not Hispanic/ Latino

Check (✓) one or more racial identities: American Indian or Alaskan Native Asian Black or African American awaiian or other Pacific Islande White Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: Total Income **Per**: Week Every 2 weeks Twice a month Monthly Year **Household Size**: House Hol

Categorical Eligibility: check (✓) if applicable **Eligibility**: check (✓) one Free Reduced Paid

Day Care Homes Only: check (✓) one Tier I Tier II

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: Dashay Brown **Date**: Select date

Confirming Official's Signature: _____ **Date**: Select date

Follow Up Official's Signature: _____ **Date**: Select date

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

Dashay Brown

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits on the Annual Income Eligibility Guidelines.

Household Size	Yearly Income
1	**Please refer to the Income Eligibility Guidelines that are updated annually and available at** **https://www.decal.ga.gov/documents/attachments/Incomeeligibguidelines.pdf**
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: 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 your child for free or reduced-price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

12/2022

Sources of Income Chart[1]

INSTRUCTIONS

Households that receive SNAP, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a SNAP, TANF, or FDPIR case number. For adult day care, list participant's name and a SNAP, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children. Note:** Children in Foster care, enrolled in Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Please refer to the Q&A section for a definition of each free categorical eligibility.
Part II: Skip this part.
Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.
Part II: To report total household income from last month, complete the following:
A- Child Income: Please indicate the TOTAL income received by **Child** household members listed in PART I. Please list any child income and how often it is received in this section.
B – Adult Income: List the first and last name of each **Adult** person living in your household as an economic unit. You must indicate yourself and all other adult members living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant should be listed here as well. Attach another sheet if necessary.
List Gross Income. Next to each person's name, list each type of income received last month, and how often it was received.
B-Column 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
B-Column 2: List the amount each person got last month from welfare, child support, alimony.
B-Column 3: List Social Security, pensions, and retirement.
B-Column 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Social Security Number: If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or mark the "I don't have a Social Security Number" box.
If no income: If the person does not receive income from any source, write "0". If "0" is entered or any income fields are blank, the person is certifying that there is no income to report. Please note that the last four digits of his or her Social Security Number is REQUIRED when/if **Part II B** is completed and household members are listed (with or without income).

Sources of Income for Children	
Sources of Child Income	**Example(s)**
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults		
Earnings from Work	**Public Assistance / Alimony / Child Support**	**Pensions / Retirement / All Other Income**
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	▪ Social Security (including railroad retirement and black lung benefits) ▪ Private pensions or disability benefits ▪ Regular income from trusts or estates ▪ Annuities ▪ Investment income ▪ Earned interest ▪ Rental income ▪ Regular cash payments from outside household

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

C – Total Household Members. Please list the total number of all household members (children and adults) in this section.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must complete this section completely and then sign the form. Please refer back to Part II to ensure the last four digits of his/her social security number have been recorded or the box has been marked if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

o

The Child and Adult Care Food Program

Income Eligibility Statement Form and Supporting Documents

The United States Department of Agriculture (USDA) issued revised Income Eligibility Statements (IES) and other required forms to all state agencies to disseminate to institutions participating in the Child and Adult Care Food Program (CACFP). The newly revised IES package includes the following: IES form and instructions, reduced income guidelines template with privacy and non-discrimination statement, Sharing Information with Medicaid/SCHIP letter, sample house-hold letters based on program type, and template letters to use when verifying income and reporting the results of the verification. This newly revised IES application conforms to USDA's newly released prototypes and therefore meet all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

The revised IES package and supporting documents is available at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

Frequently Asked Questions

Q. What information do I issue to parents?

A. Institutions and facilities should issue the (1) IES form, reduced income guidelines with the privacy and non-discrimination statement, (2) appropriate household letter, and the (3) Sharing Information with Medicaid/SCHIP letter to parents/guardians of children/adults participating in the CACFP.

Q. Can centers/day care homes require parents/guardians to complete the IES form as part of the enrollment package?

A. Centers/day care homes can **request** that parents/guardians complete the form as part of the enrollment process, but centers should **not require** parents/guardians to complete the form nor should they have policies/practices in place that negatively impacts the prospective/current participant's enrollment if the parent declines or fails to complete or submit the form. This action would be in violation of the Program.

Q. If the parent, guardian, or adult member completing the form does not specify income but lists household members in Part II B, are the last four digits of the social security number required?

A. Yes, when a free or reduced eligibility determination is based upon Part II, whether income is specified or not specified, the last four digits of the social security number is required. As per the Privacy Act Statement, the information provided is used to determine if the child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs.

Q. Why is it necessary to issue the Sharing Information with Medicaid/SCHIP letter to parents?

A. Parents/guardians that do not wish to have their information shared with either Medicaid or SCHIP must complete the form and return to facility. Otherwise and when requested by Bright from the Start or the United States Department of Agriculture (USDA), parent/guardian information will be shared with Medicaid/SCHIP.

Q. Is it necessary to have three official's signatures on the new IES form-especially when the center is an independent center with only one staff person managing the CACFP?

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

A. No. Only one signature is required for Independent centers with only one staff person responsible for managing the CACFP. However, institutions with more than one person managing the CACFP, and center and administrative sponsors are required to have a minimum of two signatures: **determining official and confirming official**.

Q. What is the purpose of having a determining and confirming official signature?

A. The confirming official will review the form and ensure accuracy and completeness. IES forms are considered current and valid until the last day of the month in which the form was dated on year earlier. The date to be used to make this determination is the date in which the sponsor or institution official signs the IES form to certify eligibility of the participant.

Q. How long is the IES form considered current and valid?

A. IES forms are considered current and valid until the last day of the month in which the form was dated one year previously. The date used to make this determination is the date in which the sponsor/ independent center official or parent/guardian signs the IES form. CACFP institutions and SFSP sponsors must decide which date they will use as the effective date and apply this date to all income eligibility forms submitted on behalf of all participants. CACFP institutions and SFSP sponsors are required to complete the **Income Eligibility - Effective Date Option Form.** In addition, institutions must indicate the options chosen in Section VIII. Recordkeeping (Item #2) of their Management Plan.

This means that sponsor and independent center officials should not request parent/guardians to complete IES forms at a specific frequency (e.g. start of each school year, every June, etc.). Request made by the sponsor or independent center official for IES form completion should be based solely on the expiration date of the IES forms.

Q. Do I send a report to Bright from the Start listing parent/guardians that want their information shared with Medicaid/SCHIP?

A. No. When instructed by USDA, Bright from the Start will request and collect data from institutions.

Q. Can this form be used for children in childcare facilities and adults in adult daycare facilities?

A. Yes.

Q. Can siblings be listed on one form?

A. Yes. Siblings from the same household can be listed on one form as long as there is space available.

Q. When do I verify parent/guardian income?

A. At the request of the United States Department of Agriculture (USDA), Bright from the Start, or any of its agents.

Q. Where can I get copies of the IES form and supporting documents?

A. Access Bright from the Start's webpage at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

Q. Can I still participate in the CACFP if parents do not complete the IES form or do not return the form to my center?

A. Yes. However, children that do not have IES forms on file must be placed in the "**paid**" category on the roster, which will effect monthly reimbursement. Centers that are using the IES form to capture annual enrollment information will be required to use an alternate enrollment form that captures at a

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

minimum the name of the child, normal hours and days of care and meals the child usually receives while in attendance.

Q. What if the form is completed by the parent but is not signed and dated by the sponsor or independent official. Is the form valid?

A. The form would neither be current nor valid for free or reduced price meals since the signature and date of the sponsor or independent official is the certification of the eligibility of the participant.

Q. Are households required to report changes in circumstances?

A. No, Public Law 108-265 modified the requirements related to reporting changes in income during the period of eligibility covered by the application. Households are not required to report changes in circumstances, such as increase in income, a decrease in household size, or when the household is no longer certified eligible for benefits through Supplemental Nutrition Assistance Programs (SNAP) or Temporary Assistance for Needy Families (TANF).

Q. Are temporary approvals (45 days) still required when no income is reported?

A. No. Temporary approvals previously provided for short term assistance, such as when a household experienced a temporary income reduction or when no income was reported have been eliminated, are no longer required. Now, year-long eligibility includes households that report no income on their IES forms.

Q. Can parents list some but not all of the household income received?

A. No, the IES form requests all the household income including the frequency. By signing the IES form the parent/guardian certifies that all the information on the form is true and that all income is reported and that they understand that the center or day care home will receive Federal funds based on the information listed by the parent/guardian.

Q. Do children participating in Head Start or Early Head Start need to complete additional income eligibility forms to qualify for free meals?

A. Children enrolled in federal and state-funded Head Start or Early Head Start Programs are categorically eligible to receive free meal benefits without further application or eligibility determination. Categorical eligibility means Meal Benefit Forms are not required.

Eligibility determinations for the CNPs are made on an annual basis. As long as the child is enrolled in Head Start or Early Head Start at the time the annual eligibility determination is made, all reimbursable meals served to that child may be claimed at the free rate.

Institutions, sponsors, and school food authorities may establish eligibility of all Head Start enrollees through documentation provided by the Head Start program. Forms of acceptable documentation include:

- Approved Head Start application
- Statement of Head Start enrollment
- List of participants from a Head Start official

Q. If a child who is eligible for Head Start benefits also attends a child care center or day care home, is the child automatically eligible for free CACFP meals at the child care facility without further application or eligibility determination?

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

A. Yes. All CACFP reimbursable meals served to children enrolled in Head Start or Early Head Start may be claimed at the free rate by child care centers or at Tier I rates in day care homes in which they are enrolled. Documentation of acceptable Head Start eligibility must be maintained.

Q. Are the siblings or other children who are members of a Head Start child's household also automatically eligible for free meals without further application?

A. Only children enrolled in Head Start are categorically eligible. Categorical eligibility based on Head Start enrollment does not extend to all children in the same household.

Q. Can a day care home document its eligibility for Tier I reimbursement based on the provider's own child's enrollment in a Head Start program?

A. The Improving Head Start for School Readiness Act of 2007 (Public Law 110-134) extended categorical eligibility only to children enrolled in Head Start; therefore, a child's Head Start enrollment does not extend to the provider.

Q. Are children who are enrolled in Head Start, but who are members of households that are above the Head Start income eligibility requirements, still eligible for CACFP meals at the free rate?

A. Yes. All reimbursable meals served to children enrolled in Head Start may be claimed at the free rate. Head Start serves primarily children from families with household incomes at or below the federal poverty level. However, a small proportion of children in families with household incomes above the poverty level may also be served.

Public Law 110-134 amended sections 9(b)(12)(A)(iii) and 17(c)(5) of the Richard B. Russell National School Lunch Act to make any child enrolled in Head Start categorically eligible for free meals without further application or eligibility determination.

Q. Are children enrolled in state-funded prekindergarten programs eligible for free meals?

A. Children participating in state-funded prekindergarten programs are not automatically eligible for free meals. In California, the income eligibility requirements for state-funded preschools are less stringent than the requirements for the Head Start Program. Therefore, determinations of eligibility for free meals for participants must be made on an individual basis.

Section 107 of the Child Nutrition and WIC Reauthorization Act of 2004 (Act) amended section 9(b) of the Richard B. Russell National School Lunch Act to make runaway, homeless and migrant children categorically eligible for free meal benefits under the National School Lunch and School Breakfast Programs and is effective July 1, 2004.

Q. What is the definition of homeless?

A. The term "homeless children" has the meaning given to "homeless children and youths" in section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)).

"Homeless children" means:

1. Individuals who lack a fixed, regular, and adequate nighttime residence; and

2. Includes -

    a. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; are

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

b. Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

c. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

d. Migratory children who qualify as homeless because they are living in circumstances described in a-c above.

Q. What is the definition of migrant?

A. Migrant family means, for purposes of CACFP eligibility, a family with children under the age of compulsory school attendance who changed their residence by moving from one geographic location to another, either intrastate or interstate, within the preceding two years for the purpose of engaging in agricultural work and whose family income comes primarily from this activity.

Q. What is the definition of runaway youth?

A. The term "runaway", used with respect to a youth, means an individual who is less than 18 years of age and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian. https://definitions.uslegal.com/r/runaway-youth

Q. What is the definition of Foster care?

A. Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child-care institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the state or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is federal matching of any payments that are made.

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.* Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced-price meals.).

□ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address:_____

For more information, you may call _____ at _____

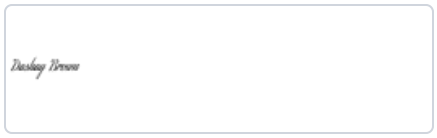
CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHIP.

Document Ref: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

Signature Certificate

Reference number: 7AF830AB-FF49-4F27-8A03-50A4A672F73E

Sent on **September 14, 2026 7:29 PM UTC**

Signed By	Signature
Dashay Brown dashaybrown344444@gmail.com Viewed: September 14, 2026 7:29 PM UTC Signed: September 14, 2026 7:47 PM UTC	 IP address: 2603:3001:538:c100:cdf9:13ab:2b52:239f Location: Atlanta, US

Document completed by all parties on
September 14, 2026 7:47 PM UTC

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

Child's Name (First, Middle, Last): Yasir Lahori

Date of Birth: 4/29/2022 **Gender**: ☒ Male ☐ Female

Home Address: _____
Street City State Zip Code

Parent/Guardian Name (First, Middle, Last): _____

Parent/Guardian Contact Information:

Primary Phone#: _____ Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☐ **Distance visual acuity chart** (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ **Instrument-based/Photoscreener** (**Alternative method; see guidance below)

Results:
☐ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☐ **Pure tone audiometry** (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ **Automated Otoacoustic Emissions** (**Alternative method; see guidance below)

Results:
☐ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

DENTAL

Results:
☒ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☒ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

OCT 08 2026
Dwayne Turner, DDS
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

NUTRITION

Results:
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 in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

Vision and Hearing Screening Method Guidance:

* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

YMCA EARLY LEARNING PROGRAMS
HEAD START & EARLY HEAD START PROGRAMS

Family Partnership Agreement

School Year: 26-27

Child's Name: Yasir Lahori **Site:** Kidazzle - Summit

Parent/Guardian Name: **Relationship to Child:**

The YMCA Early Learning programs consider and strongly support families as their children's first and most important teachers. Our collaboration with families is crucial to creating a learning environment that promotes school readiness skills and supports family well-being. This agreement is a partnership between our program and you as the primary educators to support your child's early childhood education and development at the center and in the home setting. Every year we ask our families to sign a Partnership Agreement to acknowledge their participation and commitment to their children's education and their partnership with our program staff.

FAMILY PARTNERSHIP PROCESS: Work with your child's Head Start/Early Head Start staff to collaborate to identify interests, needs, strengths, goals, and services and resources that support well-being, including family safety, health, and economic stability.

FAMILY NEEDS ASSESSMENT: Work with your child's Head Start/Early Head Start staff to identify family strengths and needs related to the family engagement outcomes as described in the Head Start Parent Family and Community Engagement Framework.

ATTENDANCE: Have your child ready for school and on time daily. It is important for children to come to school every day (except if the child is ill)

PARENT MEETINGS: Participate in the leadership of your child's site by attending monthly meetings, discussing issues, and advising staff.

PARENT/ TEACHER CONFERENCE and HOME VISITS: Attend scheduled conferences and home visits.

READ AT HOME: Complete and return all at-home learning activities sent home by program staff (for example: Healthy Reading). Read to your child at least 20 minutes each day.

PARENT TRAINING QUESTIONNAIRE: Complete a parent training questionnaire annually to help the program identify resources and engagement opportunities.

PARENT ENGAGEMENT OPPORTUNITIES: Participate in workshops, conferences, and other opportunities provided by Head Start to help families meet their goals.

HEALTH: Take your child to the doctor and dentist for regular checkups and follow up with any treatment needs. Ensure your child maintains up-to-date health status throughout the school year.

VOLUNTEERING: Commit to volunteering in your child's Early Learning Center.

FAMILY GOALS: Work with your child's Head Start/ Early Head Start staff to set and achieve family goals that promote your child's success and school readiness.

- **The parent is interested in setting a goal:** ☒ **Yes** ☐ **No** ☐ **Not at this time**

Parent Signature — Date 10/21/26

Staff Signature — Date

Family Information, Income & Contacts

This Section for Agency Use Only:

Applicant Name: LAHORI, YASIR Birthday 4/29/2022

Family Information

Living Address	Address Line 2	Zip	City	State	County
760 OLD DOVE LN		30213	FAIRBURN	GA	FUL
Mailing Address (if different)	**Address Line 2**	**Zip**	**City**	**State**	**County**

Parental Status	Primary Lang. at Home	Acquiring New Language	Relationship to Participants	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency
One	English	No	Parent(s) (e.g. biolo				

Family Income

TANF	Supplemental Security Income	SNAP	WIC	WIC ID (if applicable)
No	No	Yes	No	

Date Verified (agency use 6/25/2026 Verified by (agency use Thomas, Paris

Family Member	Amount	Per (for example: week, month, year)	Annual Amount	Description (for example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Notes

Income Notes

6/25/2026 10:49 AM Paris Thomas
Family submitted SNAP as proof of income.

Emergency Contacts

Contact 1

Name	Relationship	Contact For	Emergency Contact	Release To
JAMAL LAHORI	Father	Family	Yes	Yes
Address	**Zip**	**City**		**State**
Phone # 1	**Phone # 2**		**Phone # 3**	
	( ) -		( ) -	

Contact 2

Name	Relationship	Contact For	Emergency Contact	Release To
AASHA BROWN	Grandmother	Family	Yes	Yes
Address	**Zip**	**City**		**State**
Phone # 1	**Phone # 2**		**Phone # 3**	
(515) 867-4050Cell Phone	( ) -		( ) -	

Contact 3

Name	Relationship	Contact For	Emergency Contact	Release To
DAJANER BROWN	Aunt	Family	Yes	Yes
Address	**Zip**	**City**		**State**
Phone # 1	**Phone # 2**		**Phone # 3**	
(515) 556-2783Cell Phone	( ) -		( ) -	

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature Dashay Brown Date 10/2[illegible]/26

© 2026 ChildPlus by Procare Solutions. All rights reserved.

Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
YASIR	JAHMAL	LAHORI			4/29/2022	Male	444-47-2153

Race and/or Ethnicity	English Proficiency	Other Language	Other Language Proficiency
Black or African American	Proficient		

Primary Health Coverage	Other Health Coverage	Insurance #	Medicaid	Medicaid #

Doctor	Dentist

Adult 1

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
DASHAY	MARIE	BROWN			5/24/1999	Female	- -

Race and/or Ethnicity	English Proficiency	Other Language	Other Language Proficiency
Black or African American	Proficient		

Highest Grade Completed	Employment Status	Child's Relationship	Custody	Check all that apply:
College Degree/Training Cer	Full-time (35 hours/week	Biological/Adopted/	Yes	Lives with Family Provides Financial Support

Phone Numbers	Type	Note (e.g. extension or best time to call)
No Phone Numbers		

Email: DASHAYBROWN34@GMAIL.COM

Additional Child (Applicant)

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
EAST	KALLAN	LAHORI			3/29/2021	Female	760-43-6977

Race and/or Ethnicity	English Proficiency	Other Language	Other Language Proficiency
Black or African American	Proficient		

Check all that apply:
Lives with Family

* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

© 2026 ChildPlus by Procare Solutions. All rights reserved.

Applicant Eligibility & Enrollment Information

This Section for Agency Use Only:

Applicant Name: LAHORI, YASIR Birthday 4/29/2022

Eligibility

Program Term	Agency	Site	Classroom	Funding
2026-2027 Head Start NE/Me	YMCA/Early Learning	30-KIDAZZLE	K5-ROOM 7 (Summit)	2025-2030 NE/Metr

Application Status	Application Number	Application Date	Waitlisted Date	Accepted Date
Complete & Verified	419645	6/25/2026	6/25/2026	7/8/2026

Enrollment Date	Entry Date	Releases Signed	Date Signed	Child will transition to
8/3/2026	8/3/2026			

Enrollment Notes

6/25/2026 10:58 AM Paris Thomas
Family has submitted required documents for enrollment, student has been waitlisted.

Eligibility Date	Eligibility Income	Number in Family	Income Status	Participation Year
6/25/2026	$0.00	3	Homeless	1

CACFP Date	CACFP Income	Per (for example, year, month, other)	CACFP Status
8/3/2026	$0.00	Year	Free (Full Reimbursement)

Eligibility Criteria

Eligibility Question	Answers	Points
Parental Status	Single Parent	90
Disability Status	Not Applicable	0
Residence	In Target Area	80
Child Health Status	Not Applicable	0
Other Status	Employed Parent	50
Dual Language Learners		0
Early Head Start		0

Income	180
Class Age	90
Returning	0
Adjustment	0
Total Points	490

Eligibility Notes

6/25/2026 12:57 PM Paris Thomas
Child is age and income eligibility.

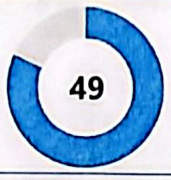
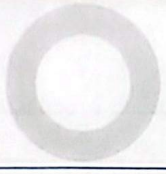
Family Application added by KAREN HARRIS on 8/20/2025 at 3:40 PM

© 2026 ChildPlus by Procare Solutions. All rights reserved.

YMCA/Early Learning

4230 - Family Outcomes - Family Profile

Program Term: 2026-2027 Head Start NE/Metro Atlanta, Site: 30-KIDAZZLE

YMCA/Early Learning	Preliminary	End of Year		Gains*
YASIR LAHORI's Family *ID: 119946*	KAREN HARRIS Completed 09/30/2026	Due 03/01/2027	Not Due	
2026-2027 Family Needs Assessment *Lower Score Means Greater Need*				
Family Well Being	**31 86%**			
Housing	3			
Health - Dental & Medical Care	3			
Health Insurance	4			
Mental Health	4			
Transportation	3			
Financial Security	3			
Employment	3			
Food & Clothing	4			
Safety: Home, Domestic Violence, Car Seat, Legal	4			
Positive Parent-Child Relationships	**3 75%**			
Supportive Relationships	3			
Family as Life Long Educators	**3 75%**			
School Readiness	3			
Families as Learners	**3 75%**			
Adult Education	3			
Family Engagement	**3 75%**			
Transition	3			
Connections to Peers/Community	**3 75%**			
Family and Community Involvement	3			
Families as Advocates	**3 75%**			
Leadership and Advocacy	3			
Grand Total	**49 82%**			

Frequency of Responses:	
1.0 - Urgent Need	0
2.0 - Needs Assistance	0
3.0 - Stable	11
4.0 - Strength	4

*Gains are calculated by comparing results from the first and most recent assessments.
The number of days between these two assessments is also shown

© 2026 ChildPlus by Procare Solutions. All rights reserved.

YMCA/Early Learning

4230 - Family Outcomes - Family Profile

Program Term: 2026-2027 Head Start NE/Metro Atlanta, Site: 30-KIDAZZLE

Notes

Preliminary

Parent Signature Dashawy Brown
Date 12/22/26

FSA Signature _____
Date _____

End of Year

*Gains are calculated by comparing results from the first and most recent assessments.
The number of days between these two assessments is also shown

© 2026 ChildPlus by Procare Solutions. All rights reserved.

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER
Yasir Lahori	4-29-2022	KIDazzle

HEALTH CARE PROVIDER INFORMATION

PHYSICIAN ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE
5887 Talking Dr Suite 230, Sandy Springs, GA 30328	Dr [signature]

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
		10/23/26

ADDRESS

VITIALS SIGNS: TEMP: 97.8F PLUSE: 96 SPO2: 100

EXAMINATION RESULTS

HEIGHT: 38 inches WEIGHT: 36 lbs/oz 4 BLOOD PRESSURE: 106/54

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin	✓		Mouth/ Teeth/ Oral Health Assessment	✓		Genitalia		
Head	✓		Throat	✓		Neurologic	✓	
Neck	✓		Chest	✓		Extremities	✓	
Lymph Nodes	✓		Lungs	✓		Motor Ability	✓	
Eyes	✓		Heart	✓		Psychological	✓	
Ears	✓		Back	✓		Speech	✓	
Nose	✓		Abdomen	✓		Developmental	✓	
						Behavioral		✓

Vision Acuity		Right	Left	Both
Date	10/23/26	20	20	20
Test Type	Passed	20	20	20

Hearing Screening	
Date	10/23/26
Test Type	Passed

Frequency (Hz)	Right (db)	Left (db)
1000 Hz	✓ dB	✓ dB
2000 Hz	✓ dB	✓ dB
3000 Hz	✓ dB	✓ dB
4000 Hz	✓ dB	✓ dB

Hemoglobin

☐ No Risk, screening not required (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ Risk factors NOT present: TB SKIN TEST NOT REQUIRED

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ

DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE

Lead Risk Assessment

☐ At Risk ☑ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Normal physical findings; assistance w/ behavior & cooperation

Treatment/Restrictions/Recommendations for School

Continue education

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No (If yes, Medication Administration form needed)

Child is physically and emotionally able to participate in program ☐ Yes ☐ No (If no, please explain in space above)

TYPE OF MEDICATION AND PURPOSE

HEALTH ASSESSMENT SCREENING

ABSOLUTE CARE PEDIATRICS

7/18 **Distribution:** White – Child's File Canary – Parent

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form: _____ **Staff Name:** Dr. [signature] DNP

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: Yasir (first) Lahori (middle) _____ (last)

Date of Birth: 04 / 29 / 2022 **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

_____ 10/23/2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-866-3596

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

_____ 10/23/2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-866-3596

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: 38 Weight: 36.4

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

_____ 10/23/2026
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-866-3596

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:

DPH Form 3300 Rev. 2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Lynn, Julia	**State Student ID:** 2609556
Date of Birth: 04/07/22	**Classroom:** Room 7
Parent / Guardian: Karen Elizabeth Platt & Matthew Lynn	**Contact Phone:** 404-718-0932

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (2 PENDING)
Remaining items needed for 100% compliance: **Child Physical SSN Card; Form 3300 (Screening Certificate)**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Lynn_Julia.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_98efb4.pdf	9	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609556
Student Name: Lynn, Julia	**Date of Birth:** 04/07/22
Parent(s)/Guardian: Karen Elizabeth Platt & Matthew Lynn	**Phone:** 404-718-0932

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609556
Scan the QR code or click the link above. Use child's Date of Birth (**04/07/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Lynn, Julia** Parent Signature: _____ Date: _____

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-27 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME: KIDAZZLE- SUMMIT	

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)			
CHILD'S LAST NAME: LYNN			
CHILD'S FIRST NAME: JULIA			
CHILD'S MIDDLE NAME: ANTOINETTE	NAME SUFFIX:		(i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#: 755 21 0761	D.O.B. (MM/DD/BY): 04/07/22	SEX: [ ]M [F]	
HOME ADDRESS (*Do not enter PO Box Info*): 990 Cooper Lake Rd SE	COUNTY: Cobb		
CITY: Smyrna	STATE: GA	ZIP: 30082	HOME PHONE: (770 826 5163

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: Platt	FIRST: Karen	MIDDLE INITIAL: E	
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: (770) 826 5163	Cell Phone: ( )		
Email Address: Karen.e.platt@gmail.com			
Place of Employment: US Citizenship & Immigration	Work Phone: (404) 984-0319		
Address: 401 W. Peachtree St. NW ste 2500			
City: Atlanta	State: GA	Zip: 30308	
Parent/Guardian #2 - LAST NAME: Lynn	FIRST: Matthew	MIDDLE INITIAL: D	
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: ( )	Cell Phone: (504) 657-0977		
Email Address: matt.d.lynn@icloud.com			
Place of Employment: Kuehne + Nagel	Work Phone: (404) 675-2800		
Address: 4100 N Commerce Dr.			
City: East Point	State: GA	Zip: 30344	

EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)

NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1. Teresa Platt	Grandmother	770-826-5162		terplatt@aol.com
2. Lindsey Harris	Friend	770-827-0766		lindsey.sievers@yahoo.com

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: Karen Platt DATE: 1/16/26

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. Teresa Platt	160 Creekview Trail Clayton GA	Grandmother	770-826-5162
2. Lindsey Harris	4064 Wilding Valley Dr Smyrna GA	Friend	770-827-0766
3. Phil Harris	" " "	Friend	770-733-9416
4. Blake Thompson	2220 Soaring Ln Lawrenceville GA	Great Uncle	404-545-7011

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Anna Bramwell

DATE OF LAST FULL HEALTH SCREENING: 4/30/25 PHONE: (404) 351-6662

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

Ø

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

Ø

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:

Ø

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): Karen Pratt

DATE: 11/26/26

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, Julia Lynn, 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: Kidazzle, Peachtree Summitt

SIGNATURE (Parent/Guardian): Karen Pratt

DATE: 11/26/26

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning _____ (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Kaiya Scott
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast **Lunch** **Afternoon Snack** **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: Laura Platt

Date: 1/16/26

Facility Administrator Signature: K. Hans

Date: 2/10/26

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security # ____-____-____	DOB (M/D/Y): ____/____/____	Gender: M ☐ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): ____/____/____	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	Other ☐
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☐ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☐ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☐ **No**

_____

Parent/Guardian Signature **Date**

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: Kayne Platt **Date:** 11/6/26

Administrative Signature: K. Harris **Date:** 2/10/26

Teacher Signature: _____ **Date:** _____

Rev. 07/2020

Georgia Department of Public Health

Form 3231

CERTIFICATE OF IMMUNIZATION

LYNN, JULIA ANTOINETTE
Child's Name (Last name, First name)

04 | 07 | 2022
Birthdate

PLATT, KAREN ELIZABETH
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2034
Date of Expiration
(Next required immunization or review of medical exemption due.)

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	06 08 22	08 08 22	10 12 22	07 10 23	05 07 26		5				
Polio	06 08 22	08 08 22	10 12 22	07 10 23	05 07 26		5				
Hepatitis B	04 07 22	05 06 22	04 10 23				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	06 08 22	08 08 22	10 12 22	07 10 23			4				
PCV (Under Age 5)	06 08 22	08 08 22	10 12 22	04 10 23			4				
Measles	04 10 23	05 07 26					2				
Mumps	04 10 23	05 07 26					2				
Rubella	04 10 23	05 07 26					2				
Hepatitis A (Born on/after 1/1/06)	11 09 23	05 23 24					2				
Varicella	07 10 23	05 07 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	06 08 22	08 08 22	10 12 22				3				
HPV							0				
Influenza	10 12 22	01 13 23	11 09 23	10 02 25			4				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Piedmont Pediatrics, LLC
Allison Thornton, M.D.
Elizabeth Smith, M.D.
Laura E. Harris, M.D.
David C. Roe, M.D.
Steven M. Elliott, M.D.
Anna M. Bramwell, M.D.
2021 Peachtree Rd. NE, Suite 400
Atlanta, GA 30309
Phone: 404-851-6030 Fax: 404-851-6036

Certified by (Signature/Signature Stamp)

MAY 07 2026
Date of Issue

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

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: Julia (first) Lynn (middle) _____ (last)

Date of Birth: 04/07/2022 **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

AMramwell MD MAY 07 2026

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Piedmont Pediatrics
2021 Peachtree Rd. NE Ste 400
Atlanta, GA 30309
P: 404-351-6662, F: 404-351-6030

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

AMramwell MD MAY 07 2026

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Piedmont Pediatrics
2021 Peachtree Rd. NE Ste 400
Atlanta, GA 30309
P: 404-351-6662, F: 404-351-6030

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: 42.5in Weight: 43

BMI: 16.74 BMI%: 84.27%

- ☑ 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

AMramwell MD MAY 07 2026

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

Piedmont Pediatrics
2021 Peachtree Rd. NE Ste 400
Atlanta, GA 30309
P: 404-351-6662, F: 404-351-6030

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:

*Dental screening is to be performed by a Dentist.

Piedmont Pediatrics, LLC
Allison J. Koenig, M.D.
Elizabeth J. Griffith, M.D.
Laura E. Harris, M.D.
David C. Roe, M.D.
Steven M. Elliott, M.D.
Anna M. Bramwell, M.D.
2021 Peachtree Rd. NE, Suite 400
Atlanta, GA 30309
Phone: 404-351-6662 Fax: 404-351-6030

DPH Form 3300 Rev. 2025

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: McKenzie, Kyus Antonio	**State Student ID:** 2609525
Date of Birth: 04/06/22	**Classroom:** Room 7
Parent / Guardian: Myshell K. Mooney	**Contact Phone:** 404-808-1429

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (4 PENDING)
Remaining items needed for 100% compliance: **Child Physical SSN Card; Form 3300 (Screening Certificate); Parent Photo ID; CACFP Income Statement**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_McKenzie_Kyus_Antonio.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Kyus_McKenzie.pdf	1	✓ SIGNED
3	**Registration Application**	[Untitled]_c66732.pdf	19	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609525
Student Name: McKenzie, Kyus Antonio	**Date of Birth:** 04/06/22
Parent(s)/Guardian: Myshell K. Mooney	**Phone:** 404-808-1429

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
[ACTION NEEDED]	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609525

Scan the QR code or click the link above. Use child's Date of Birth (**04/06/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **McKenzie, Kyus Antonio** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Kyus
Legal Middle Name: Antonio
Legal Last Name: McKenzie
Name Suffix (Jr,II,III):
Name Child is Called:
Child's Social Security #: 654-75-1285
Date of Birth: 04/06/2022
Gender: M [X] F [ ]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Mooney
First Name: Myshell
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: skinnyminny17@yahoo.com
Zip Code: 30034

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

Parent/Guardian Signature

2026-07-31

Date

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write school year in the box →

Pre-K Registration Form School Year

2026-27

PROVIDER LEGAL NAME: (This section to be completed by the provider)

SCHOOL/SITE NAME: KIDAZZLE - SUMMIT

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)			
CHILD'S LAST NAME: McKenzie			
CHILD'S FIRST NAME: Kyus			
CHILD'S MIDDLE NAME: Antonio	NAME SUFFIX: (i.e. Jr, Sr, II,III)		
CHILD'S SOCIAL SECURITY#: 654751285	D.O.B. (MM/DD/BY): 2022-04-(	SEX: ☑ M	F
HOME ADDRESS (*Do not enter PO Box Info*): 2854 norgate court	COUNTY:		
CITY: Decatur	STATE: GA ZIP: 30034	HOME PHONE: (4044923764	

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: Mooney	FIRST: Myshell	MIDDLE INITIAL: K
Home Address (*If different from child*): 2854 norgate court		
City: Decatur	State: Ga	Zip: 30034
Home Phone: ( )	Cell Phone: ( ) 4044923764	
Email Address: Skinnyminny17@yahoo.com		
Place of Employment:	Work Phone: ( )	
Address:		
City:	State:	Zip:
Parent/Guardian **#2** - LAST NAME: McKenzie	FIRST: Antonio	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )4705131784	
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.	Daniel	Stepfather	9432276302		
2.	Chandra Jackson-dallas	Grandma	4049147159		

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: Myshell Mooney Myshell Mooney **DATE:** 2026-07-15

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. Chandra dallas		Grandmother	
2. Daniel jackson		Stepfather	
3. Shequilla mcclain		Aunt	
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Fiona blair

DATE OF LAST FULL HEALTH SCREENING: 2026-04-04 PHONE: (770)715222

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:

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-07-15 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Kyus McKenzie

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay: _____ Reg. Fee: $50.00
Total Weekly Tuition: 0

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑ **Breakfast** ☑ **Lunch** ☑ **Afternoon Snack** ☑ **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Myshell Mooney

Parent/Guardian Signature: Myshell Mooney

Date: 2026-07-15

Facility Administrator Signature: K. Hans

Date: 7/15/2026

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-07-15		
CHILD INFORMATION:		
Legal First Name: Kyus		Name Suffix (Jr,II,III):
Legal Middle Name: Antonio		Name Child is Called:
Legal Last Name: McKenzie		
Child's Social Security # 654751285	DOB (M/D/Y): 2026-07-15	Gender: M ☑ F
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): 2026-07-15	
PARENT/GUARDIAN INFORMATION:		
Last Name: Mooney	First Name: Myshell	
Relationship: Mother ☑ Father	Grandparent ☐ Guardian ☐ Other ☐	
Email Address: Skinnyminny17@yahoo.com	Zip Code: 30034	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Myshell Mooney

4. Was your child born as a:

☑ **Single Birth (1)**

Twin (2)

Triplet (3)

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☑ **Supplemental Nutrition Assistance Program (SNAP)**

☑ **Medicaid**

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

Myshell Mooney

Parent/Guardian Signature

2026-07-15

Date

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.

Myshell Mooney

SIGNATURE (Parent/Guardian): Myshell Mooney

DATE: 2026-07-15

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, Kyus McKenzie, 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 Myshell Mooney

SIGNATURE (Parent/Guardian): Myshell Mooney

DATE: 2026-07-15

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:

(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Myshell Mooney

Parent(s) or Guardians Signature: Myshell Mooney **Date:** 2026-07-15

Administrative Signature: K. Harris **Date:** 7/15/2026

Teacher Signature: _____ **Date:** _____

Bright from the Start: Georgia Department of Early Care and Learning

CACF[illegible]eal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note:** Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
McKenzie,Kyus,A	111678563597	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Myshell mooney	$0 _____/_____	$0 _____/_____	$ _____/_____	$ _____/_____
2. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.

Last four Digits of Social Security Number XXX-XX 4645 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday ☑ Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday Saturday

Circle the meals your child will normally receive while in care: ☑ Breakfast ☑ AM Snack ☑ Lunch ☑ PM Snack ☑ Supper ☑ Evening Snack

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. ***If not completed fully and signed, the participant will be placed in the Paid category.***

Signature: X _____ **Print Name:** Myshell mooney **Date:** 2026-07-1

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility**: check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

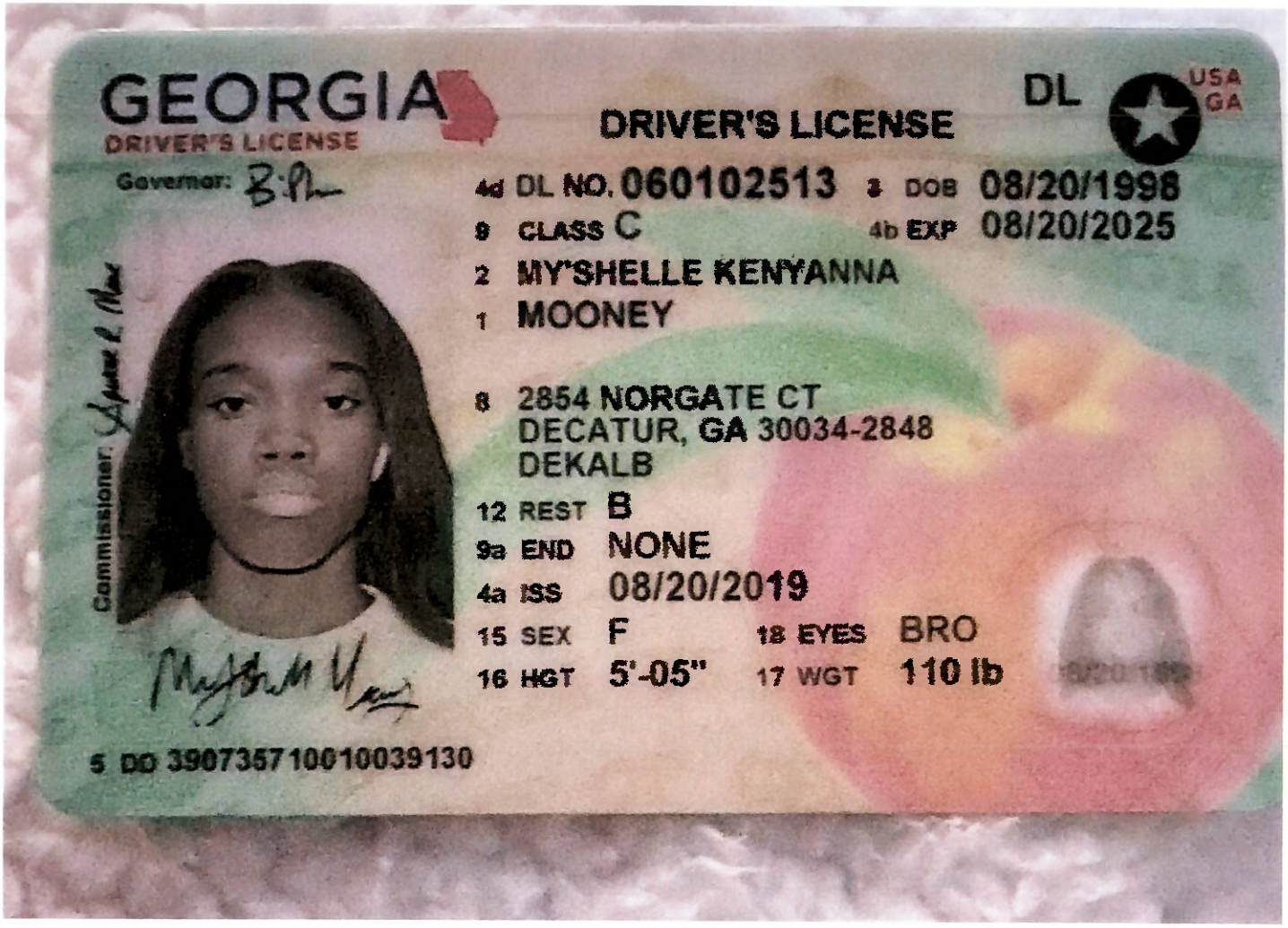
Signature Certificate

Reference number: A54BB167-067C-43DB-B4E6-3178CA1305D1

Sent on July 15, 2026 1:45 PM UTC

Signed By	Signature
Myshell Mooney skinnyminny17@yahoo.com Viewed: July 15, 2026 1:45 PM UTC Signed: July 15, 2026 2:10 PM UTC	 IP address: 2601:c4:c601:d770:91be:f74d:502d:7d99 Location: Lithonia, US

Document completed by all parties on
July 15, 2026 2:10 PM UTC



GEORGIA
DRIVER'S LICENSE

DRIVER'S LICENSE

DL

USA
GA

Governor:

Commissioner:

4d DL NO. 060102513
3 DOB 08/20/1998
9 CLASS C
4b EXP 08/20/2025
2 MY'SHELLE KENYANNA
1 MOONEY

8 2854 NORGATE CT
DECATUR, GA 30034-2848
DEKALB

12 REST B
9a END NONE
4a ISS 08/20/2019
15 SEX F
18 EYES BRO
16 HGT 5'-05"
17 WGT 110 lb

5 DD 3907357100100039130

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number | Local File Number | 1. State File Number: 2022GA000032072

2.CHILD'S NAME: FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC.	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
KYUS ANTONIO MCKENZIE	MALE	04/04/2022

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
12:22 PM	SINGLE	

11.CITY,TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital give street and Number.)
LAWRENCEVILLE	NORTHSIDE HOSPITAL GWINNETT
13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH
	GWINNETT

15. MOTHER'S NAME FIRST 16. MIDDLE 17 LAST	18.MAIDEN (Last Name)
MYSHELLE KENYANNA MOONEY	MOONEY

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
08/20/1998	GEORGIA	GEORGIA	DEKALB

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
STONE MOUNTAIN	5300 ROCK PLACE DRIVE

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
5300 ROCK PLACE DRIVE STONE MOUNTAIN GEORGIA 30087	YES

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A. ,Name Country)
ANTONIO MANUEL MCKENZIE JR	11/12/1998	GEORGIA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
MYSHELLE K MOONEY	MOTHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ EVITA SMITH	04/08/2022	(Name) BRITTAINY L DARK 37.(Title) MD

38. CERTIFIER (Type or Print)	39 PHYSICIAN'S MEDICAL LIC. NO	40. CERTIFIER-MAILING ADDRESS (Street or R F D No., City or Town,State, Zip)
(Name) EVITA SMITH (Title) BIRTH RECORD CLERK	64918	1000 MEDICAL CENTER BLVD LAWRENCEVILLE GEORGIA 30045

41 REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ CYNTHIA M. BUSKEY	04/08/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE Form 3901A (Rev. 01/2013)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF [illegible] CODE OF GEORGIA AND 511 1 3, DPH RULES AND REGULATIONS

Any reproduction of this document is prohibited by statute. Do not accept documents clearly embossed. Chapter 31 10, Code of Georgia as amended.

10032149

Cynthia M. Buskey
State Registrar

Michelle Brooks
County Registrar

STATE OFFICE GA VITAL RECORDS

C8856168

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT

APR 17 2026

STATE OF GEORGIA 1776

Form 3972 (Rev 5/15)

VOID IF ALTERED OR COPIED

DFCS - DEKALB CNTY MAIN
PO BOX 4147
ATLANTA GA 30302

1-877-423-4746

DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF PUBLIC HEALTH
DEPARTMENT OF EARLY CARE AND LEARNING

NOTICE OF DECISION

Worker ID: 886691
Worker Name: R.Buckner
Worker Phone Number: (478) 344-3062
Case Number: 120940275
Client ID: 12143178

MYSHELLE MOONEY
2854 NORGATE CT
DECATUR GA 30034 -2848

DATE: 04/15/2026

Report Medicaid Fraud: 1-800-533-0686

Dear Myshelle Mooney,

We have made a decision on your recent request for benefits.

Supplemental Nutrition Assistance Program (SNAP)

Application Date: 04/15/2026

If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

Benefit Period	Person(s)	Decision	Program Information
04/15/2026 - 04/30/2026	Myshelle Mooney Kyus Mckenzie	Approval	**Program:** Food Stamps-SNAP **Amount:** $120.00 a month See **SNAP Information** section below.
05/01/2026 - 09/30/2026	Myshelle Mooney Kyus Mckenzie	Approval	**Program:** Food Stamps-SNAP **Amount:** $225.00 a month See **SNAP Information** section below.

Supplemental Nutrition Assistance Program (SNAP) Information

We have completed your **SNAP** application received 04/15/2026. Your certification period for SNAP is for the months of April, 2026 through September, 2026.

Your benefit issuance is on the 19th of each month.

If this is the first time you have been approved for **SNAP/Senior SNAP** benefits, your Electronic Benefits Transfer (EBT) card will be mailed to you separately. If you have had an EBT card before and have lost or misplaced your card, please call Conduent Customer Service at 1-888-421-3281 or go to https://www.connectebt.com/gaebtclient/ to request a replacement card.

RESIDENTIAL RENTAL/LEASE AGREEMENT

This Residential Lease Agreement is celebrated and made effective as to the date: October 15th, 2025.

Between and by the lessor: Beverly valtroy (hereinafter referred as the "Landlord") and the lessee: Myshell mooney (hereinafter referred as the "Tenant") of the following address: 2854 norgate court Decatur ga 30034

Landlord and tenant are individually referred to as "Party" while both together and be regarded as "Parties".

THEREFORE, IN CONSIDERATION OF THE PARTIES COMMON PROMISES AND AGREEMENTS CONTAINED HEREIN, THE TENANT AGREES TO LEASE THE PREMISES FROM THE LANDLORD ON THE FOLLOWING CONDITIONS:

1. Rent.

The lease of the property has been agreed by the parties for ne value of: $250, the Lessee and Lessor are both interested in leasing the property from the l ssor on the terms outlined in this Personal Property Lease Agreement.

The Lessor shall receive all benefits of ownership of the p operty and this Agreement shall be recognized as a true lease for federal and appropriate st: e income tax reasons.

2. Type of Lease.

This contract will be regarded as a fixed lease. The le ase term (also known as the "Lease Term") for the Premises is from October 15th, 2025 until Oct ber 15th, 2030.

At the end of the Lease Term and no renewal is mac e, the Tenant must vacate/ leave the facilities.

The Tenant will pay the Rent on or before the first (1st) to fifth (5th) day of each and every month of the term of this Lease to the Landlord at 2854 norgate court Decatur ga 30034 or at such other place as the Landlord may later designate by cash, check or Venmo. If the payment address is changed at the discretion of the Lessor, the Lessee will be informed of such change by written notice.

3. Late Payments.

For any rental payment that is not paid within 3 days of its due date, Lessee shall pay a late fee

injury to the Tenant, any other person, or any property occurring on the Premises, or any part thereof, or in common areas thereof. It is recommended that the tenant purchase renter's insurance on their own expense.

26. Premises deemed as uninhabitable.

The Tenant may terminate this Agreement by giving written notice to the Landlord if the Premises is determined to be uninhabitable as a result of damage beyond reasonable repair.

If the damage was caused by the Tenant's negligence, the Tenant shall be accountable to the Landlord for all repairs and for the loss of income resulting from returning the Premises back to a habitable condition, in addition to any additional damages that the Landlord can prove.

27. Lead Based Paint.

The attachment labeled "Lead-Based Paint Disclosure" needs to be initialed and signed by both the landlord and the tenant because the premises were constructed before 1978.

Landlord's Signature: B. Valtroy

Landlord's Name: Beverly valtroy

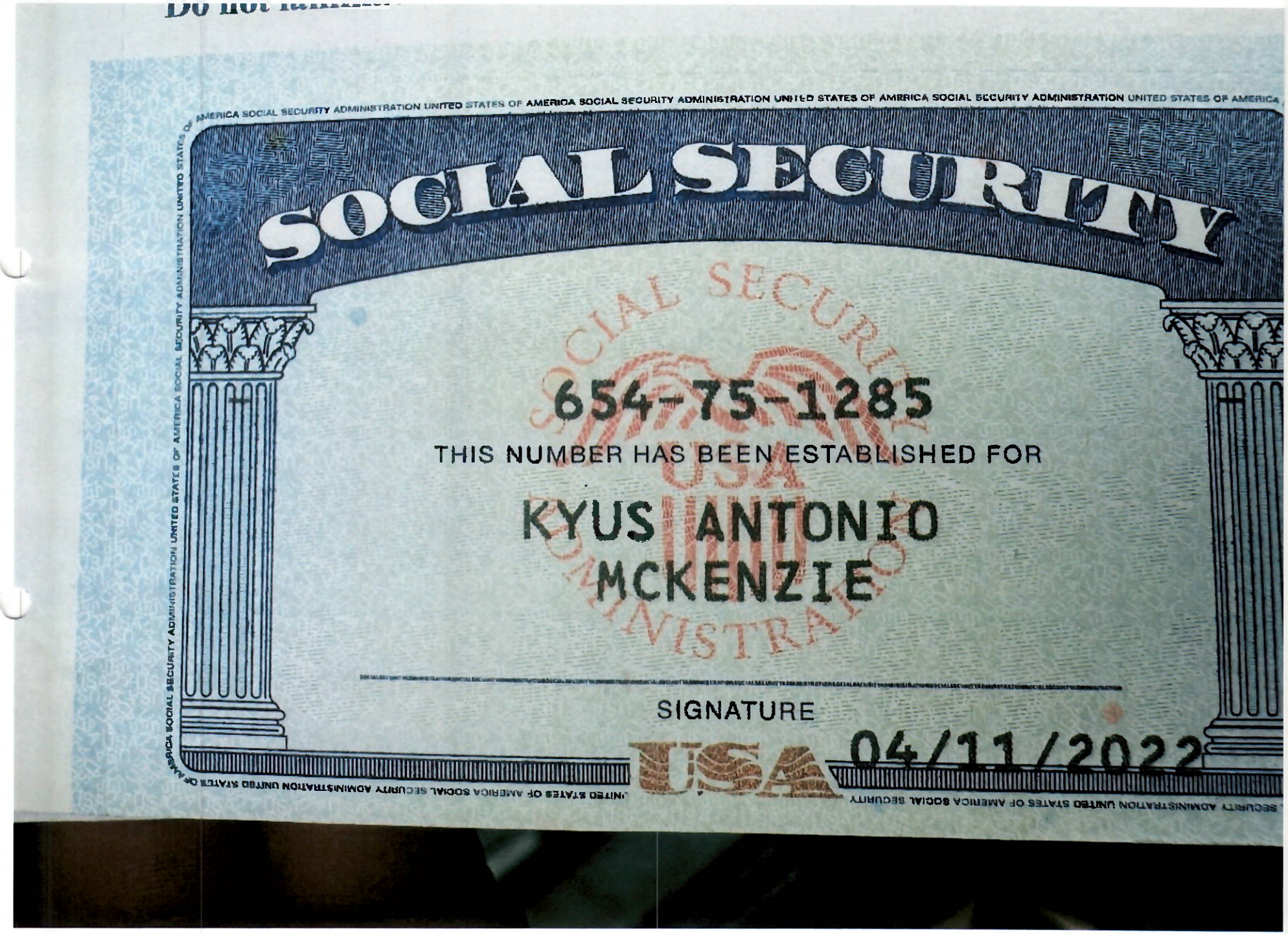
Date: 10/12/2025

Tenant's Signature: Myshell Mooney

Tenant's Name: Myshell Mooney

Date: 10/12/2025

.


SOCIAL SECURITY
654-75-1285
THIS NUMBER HAS BEEN ESTABLISHED FOR
KYUS ANTONIO MCKENZIE
SIGNATURE
04/11/2022
USA

Rev. 07/2020

Georgia Department of Public Health

Form 3231

CERTIFICATE OF IMMUNIZATION

MCKENZIE, KYUS ANTONIO
Child's Name (Last name, First name)

04 | 06 | 2022
Birthdate

MCKENZIE, KYUS
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2034
Date of Expiration
(Next required immunization or review of medical exemption due.)

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	06 14 22	08 16 22	10 17 22	10 01 24	07 31 26		5				
Polio	06 14 22	08 16 22	10 17 22	** 07 31 26			4				
Hepatitis B	04 06 22	05 12 22	01 17 23				3				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	06 14 22	08 16 22	10 17 22	05 01 23			4				
PCV (Under Age 5)	06 14 22	08 16 22	10 17 22	08 01 23			4				
Measles	08 01 23	07 31 26					2				
Mumps	08 01 23	07 31 26					2				
Rubella	08 01 23	07 31 26					2				
Hepatitis A (Born on/after 1/1/06)	05 01 23	10 01 24					2				
Varicella	05 01 23	07 31 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	06 14 22	08 16 22					2				
HPV							0				
Influenza	10 01 24						1				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Marcia A Cumberbatch M.D.
2240 West Park Place Blvd. Suite A
770-771-5222
Stone Mountain, GA 30087

80

Marcia Cumberbatch-Poole M.D.

7/31/26

FORM 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

GEORGIA DEPARTMENT OF PUBLIC HEALTH

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

Child's Name (First, Middle, Last): Kyus McKenzie

Date of Birth: 9/6/22 **Gender:** ☒ Male ☐ Female

Home Address: _____
Street City State Zip Code

Parent/Guardian Name (First, Middle, Last): _____

Parent/Guardian Contact Information:

Primary Phone#: _____ Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☒ **Distance visual acuity chart** (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ **Instrument-based/Photoscreener** (**Alternative method; see guidance below)

Results:
☒ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☒ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

Megan Waeen 7/31/26
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:
ABC Pediatric Group
2240 W. Park Place Blvd, Suite A
Stone Mountain, GA 30087
Tel:(770)771-5222/Fax(770)771-5223

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☒ **Pure tone audiometry** (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ **Automated Otoacoustic Emissions** (**Alternative method; see guidance below)

Results:
☒ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☒ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

Megan Waeen 7/31/26
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:
ABC Pediatric Group
2240 W. Park Place Blvd, Suite A
Stone Mountain, GA 30087
Tel:(770)771-5222/Fax(770)771-5223

DENTAL

Results:
☒ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☒ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

Megan Waeen 7/31/26
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:
ABC Pediatric Group
2240 W. Park Place Blvd, Suite A
Stone Mountain, GA 30087
Tel:(770)771-5222/Fax(770)771-5223

NUTRITION

Results:
Height: 42.5 Weight: 41.2
BMI: 16.04 BMI%: 65.48

☒ 5th to 84th percentile - Appropriate for age
☐ <5th percentile - Needs further evaluation
☐ ≥85th percentile - Needs further evaluation
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☒ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

Megan Waeen 7/31/26
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:
ABC Pediatric Group
2240 W. Park Place Blvd, Suite A
Stone Mountain, GA 30087
Tel:(770)771-5222/Fax(770)771-5223

Vision and Hearing Screening Method Guidance:

* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Obalo, Emmanuel Eshiozemede	**State Student ID:** 2609501
Date of Birth: 02/16/22	**Classroom:** Room 7
Parent / Guardian: Anthonia Blessing Iguoba & Matthew E. Obalo	**Contact Phone:** 404-663-7182

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Obalo_Emmanuel_Eshiozemede.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Emmanuel_Obalo.pdf	1	✓ SIGNED
3	**Registration Application**	[Untitled].pdf	2	✓ ON FILE
4	**Proof of Georgia Residency**	Utility bill-Obalo.pdf	2	✓ VERIFIED
5	**Parent / Guardian Photo ID**	image.jpg	1	✓ VERIFIED
6	**Certified Birth Certificate**	Emmanuel Obalo Birth Certtificate.pdf	1	✓ VERIFIED
7	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	EMMANUEL FORM 3300 CERTIFICATE OF IMMUNIZATION.pdf	2	✓ VERIFIED
8	**Form 3231 (Georgia Certificate of Immunization)**	EMMANUEL FORM 3300 CERTIFICATE OF IMMUNIZATION.pdf	2	✓ VERIFIED
9	**Child Social Security Card**	image.jpg	1	✓ VERIFIED
10	**Georgia Pre-K Roster Information Form (Appendix D)**	Appendix_D_Emmanuel_Obalo 9-30.pdf	1	✓ VERIFIED
11	**CACFP Income Eligibility Statement (IES)**	Matthew-1-Paystub-06-27-2026.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609501
Student Name: Obalo, Emmanuel Eshiozemede	**Date of Birth:** 02/16/22
Parent(s)/Guardian: Anthonia Blessing Iguoba & Matthew E. Obalo	**Phone:** 404-663-7182

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ RECEIVED	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ RECEIVED	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ RECEIVED	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ RECEIVED	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ RECEIVED	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ RECEIVED	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ RECEIVED	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609501
Scan the QR code or click the link above. Use child's Date of Birth (**02/16/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Obalo, Emmanuel Eshiozemede** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Emmanuel
Name Suffix (Jr,II,III):
Legal Middle Name: Eshiozemede
Name Child is Called:
Legal Last Name: Obalo
Child's Social Security #: Pending (30-Day Waiver) 02/16/2022
Gender: M [X] F [ ]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Iguoba
First Name: Anthonia
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: obalo.family@gmail.com
Zip Code: 30308

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?) Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

Parent/Guardian Signature

2026-07-31

Date

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number	Local File Number	1 State File Number
		2022GA000015155

2 CHILD'S NAME FIRST 3 MIDDLE 4 LAST 5 JR.,III,ETC.	6 SEX (M or F)	7 DATE OF BIRTH (Mo Day, Year)
EMMANUEL ESHIOZEMEDE OBALO	MALE	02/15/2022

8 TIME OF BIRTH	9 THIS BIRTH (Single Twin, Triplet, Etc.)	10 IF NOT SINGLE SPECIFY BIRTH ORDER
01:23 MILITARY	SINGLE	

11 CITY TOWN, OR LOCATION OF BIRTH	12 HOSPITAL FACILITY NAME (If not Hospital give street and Number)
CANTON	NORTHSIDE HOSPITAL CHEROKEE
13 IF NOT HOSPITAL,Specify	14 COUNTY OF BIRTH
	CHEROKEE

15 MOTHER'S NAME FIRST 16. MIDDLE 17 LAST	18 MAIDEN (Last Name)
ANTHONIA BLESSING IGUOBA	IGUOBA

19 DATE OF BIRTH (Month Day,Year)	20 STATE OF BIRTH (If not U.S.A.,Name Country)	21 RESIDENCE - STATE	22 COUNTY
10/03/1988	NIGERIA	GEORGIA	COBB

23 CITY,TOWN OR LOCATION	24 STREET AND NUMBER OF RESIDENCE
KENNESAW	615 GREENHOUSE PATIO DR APT 615

25 MOTHER'S MAILING ADDRESS	26 RESIDENCE INSIDE CITY LIMITS? (yes or No)
615 GREENHOUSE PATIO DR APT 615 KENNESAW GEORGIA 30144	NO

27 FATHER'S NAME FIRST 28 MIDDLE 29 LAST,JR , ETC.	30 DATE OF BIRTH (Month,Day,Year)	31 STATE OF BIRTH(If not U.S.A. Name Country)
MATTHEW ESHIOZEMEDE OBALO	07/08/1986	NIGERIA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER (Yes or No)
MATTHEW E OBALO	FATHER	YES

34 I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo ,Day,Year)	36 ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ KAYCE BROOKSHIRE	02/17/2022	(Name) MICHAEL HULSE 37 (Title) MD

38 CERTIFIER (Type or Print)	39 PHYSICIAN'S MEDICAL LIC NO	40 CERTIFIER-MAILING ADDRESS (Street or R.F.D No City or Town,State, Zip)
(Name) KAYCE BROOKSHIRE (Title) HOSPITAL STAFF		450 NORTHSIDE CHEROKEE BOULEVARD CANTON GEORGIA 30115

41 REGISTRAR (Signature)	42 DATE RECEIVED BY STATE REGISTRAR (Mo Day Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	02/17/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH VITAL RECORDS SERVICE Form 3901A (Rev. 01/2013)

Form 3972 (Rev.5/15)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS THIS CERTIFIED COPY IS ISSUED UNDER [redacted] 0, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS

Any reproduction of this document is prohibited by statute. Do not accept [redacted] records clearly embossed. Chapter 31-10, Code of Georgia as amended.

6605774

State Registrar

County Registrar

STATE OFFICE GA VITAL RECORDS

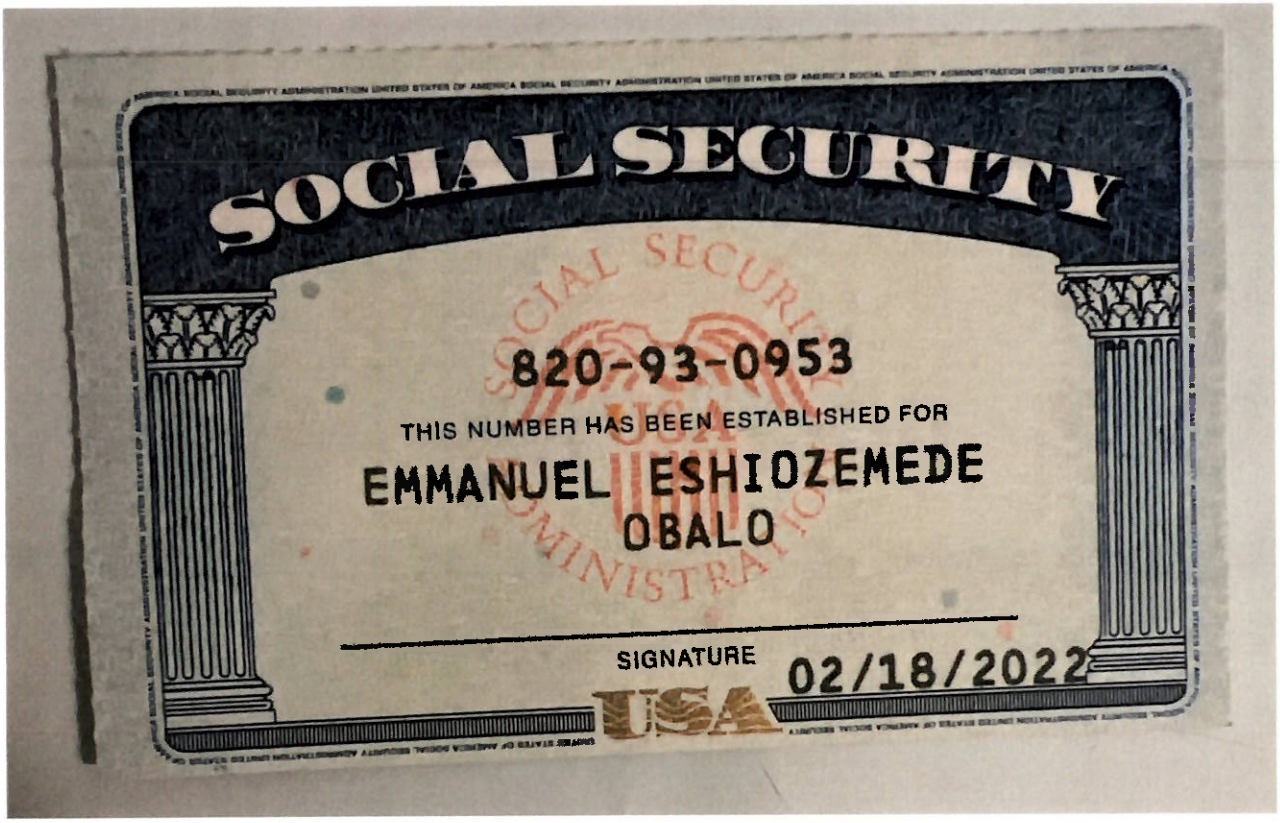
C6160743

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

FEB 3 2022

STATE OF GEORGIA 1776

VOID IF ALTERED OR REPRODUCED


SOCIAL SECURITY
820-93-0953
THIS NUMBER HAS BEEN ESTABLISHED FOR
EMMANUEL ESHIOZEMEDE
OBALO
SIGNATURE
02/18/2022
USA

NNNN

cobbemc.com | 770-429-2100

COBB EMC

FOR OFFICE USE ONLY

ANTHONIA OBALO
3725 GEORGE BUSBEE PKY #308
KENNESAW GA 30144-0000
ACCOUNT NUMBER: 634048001
SERVICE AREA DIRECTOR: MALCOLM SWANSON

See back of bill for important messages ▶

Your Account Summary

Bill Date: August 19, 2026
Service Period: July 19 - August 17 (29 Days)
Rate: NiteFlex

Previous Balance	$244.32
Payment Received - Thank you!	-$126.47
Late Fee	$10.00
Balance Forward	$127.85
Current Charges	
Service Charge	$31.90
On-Peak Charge (430 kWh @ $0.14)	$60.20
Off-Peak Charge (289 kWh @ $0.075)	$21.68
Super Off-Peak Charge (143 kWh @ $0.00)	$0.00
Capital Credits Cash Back	-$13.43
State and Local Taxes	$6.83
Total Current Charges	**$107.18**
Total Amount Due	**$235.03**

Total Amount Due

$235.03

Payment due on
September 8, 2026

▶ **Final bill:** This bill includes all final charges available as of the bill date.



Return this portion with your payment. Make checks/money orders payable to Cobb EMC. Please include your account number.

COBB EMC 1000 EMC Parkway
Marietta GA 30060

Account Number	**634048001**
Payment due on September 8, 2026	**$235.03**
Amount due after September 8, 2026	$235.03

☐ Change mailing address/phone number/email.
Turn over for details.

COBB EMC
PO BOX 745711 19
ATLANTA GA 30374-5711

4 425

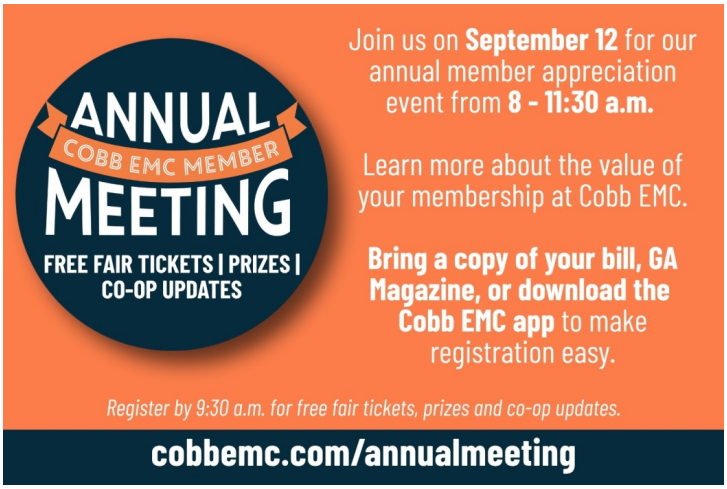
ANTHONIA OBALO
2701 CHADWICK LN NW
ACWORTH GA 30101-3472

1 09082026 0 06340480010 7 00000000012785 4 00000000023503 0 7

Meter Number	Usage Period	Start Reading	End Reading	Meter Multiplier	Meter kWh
1N6030828912	7/19 - 8/17	40076	40938	1.0	862

Message Center

- Annual Meeting: Join us on Sept. 12 at Jim R. Miller Park from 8-11:30 a.m. to learn about our progress and ways to save money and energy. More info at cobbemc.com/annualmeeting.
- Our offices will be closed September 7. Our crews and power control team are always standing by to monitor our system and respond to outages. To report an outage, text us at 898-362, visit our outage center online, or call 770-429-2100. cobbemc.com/outagecenter
- Download the Cobb EMC App: Manage your account, pay your bill, report outages, and more on the go with the free Cobb EMC app. Learn more and download today at cobbemc.com/app.



Other Ways to Pay Your Bill

Visit **cobbemc.com/pay** to see all the ways you can pay your bill. Residential members can pay online, on our app or by phone using one of these major credit cards with **no convenience fee:**

Online
Log into your account at **cobbemc.com/account.**

Phone
Call 770-429-2100 to pay by phone.

App
Pay your bill using the Cobb EMC app. **cobbemc.com/app**

In Person
Take a copy of your bill and pay by cash or debit card at any MoneyGram location, including Walmart or CVS (processing fees may apply). Or pay by cash, check or money order at our office, located at 1000 EMC Parkway, Marietta, GA 30060.

Your Cobb EMC Account Information

Is your account information up-to-date? Fill out the form below or visit **cobbemc.com/update** to update your phone number or email address. Changes may take up to two billing cycles to reflect on your account.

Mailing Address

Phone Number: (470) 577-5107

Email Address: iguobab@gmail.com

GEORGIA
DRIVER'S LICENSE

DL

USA
GA

DRIVER'S LICENSE

Governor:

Commissioner:



4d DL NO 059104850
3 DOB 07/08/1986
9 CLASS C
4b EXP 07/08/2030
2 MATTHEW ESHIOZEMEDE
1 OBALO

8 2701 CHADWICK LN NW
ACWORTH, GA 30101-3472
COBB

12 REST A
9a END NONE
4a ISS 08/16/2026
15 SEX M
18 EYES BRO
16 HGT 5'-10"
17 WGT 167 lb

5 DD 646078621760020000

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number	Local File Number	1. State File Number
		2022GA000015155

2.CHILD'S NAME: FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC.	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
EMMANUEL ESHIOZEMEDE OBALO	MALE	02/15/2022

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
01:23 MILITARY	SINGLE	

11.CITY,TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
CANTON	NORTHSIDE HOSPITAL CHEROKEE
13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH
	CHEROKEE

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST	18.MAIDEN (Last Name)
ANTHONIA BLESSING IGUOBA	IGUOBA

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
10/03/1988	NIGERIA	GEORGIA	COBB

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
KENNESAW	615 GREENHOUSE PATIO DR APT 615

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
615 GREENHOUSE PATIO DR APT 615 KENNESAW GEORGIA 30144	NO

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A. ,Name Country)
MATTHEW ESHIOZEMEDE OBALO	07/08/1986	NIGERIA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
MATTHEW E OBALO	FATHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo.,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ KAYCE BROOKSHIRE	02/17/2022	(Name) MICHAEL HULSE 37.(Title) MD

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip)
(Name) KAYCE BROOKSHIRE (Title) HOSPITAL STAFF		450 NORTHSIDE CHEROKEE BOULEVARD CANTON GEORGIA 30115

41. REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	02/17/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE

Form 3901A (Rev. 01/2013)

SECIipse® - 3

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER [illegible]0, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept [illegible] records clearly embossed. Chapter 31-10, Code of Georgia as amended.

6605773

Christopher JP Harrison
State Registrar

Dilan Barahona
County Registrar

STATE OFFICE GA VITAL RECORDS

C6160742

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

FEB 28 2022

STATE OF GEORGIA CONSTITUTION 1776

Form 3972 (Rev.5/15)

VOID IF ALTERED OR COPIED

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: Matthew (first) Eshiozemede (middle) Obalo (last)

Child's Name: Emmanuel (first) Eshiozemede (middle) Obalo (last)

Parent/ Guardian Contact Information:

Daytime phone number: 678-510-3618
Evening phone number: 470-577-5107
Cell phone number: 678-510-3618

Date of Birth: 2/15/22 **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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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: 92.4cm Weight: 34.6lbs
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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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:

DPH Form 3300 Rev. 2013

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

OBALO, EMMANUEL ESHIOZEMEDE
Child's Name (Last name, First name)

02 | 15 | 2022
Birthdate

AGUOBA, ANTHONIA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2034
Date of Expiration

(Next required immunization or review of medical exemption due.)

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	04 15 22	06 22 22	08 22 22	06 16 23	02 20 26		5				
Polio	04 15 22	06 22 22	08 22 22	02 20 26			4				
Hepatitis B	02 15 22	04 15 22	06 22 22	08 22 22			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	04 15 22	06 22 22	06 16 23				3				
PCV (Under Age 5)	04 15 22	06 22 22	08 22 22	06 16 23			4				
Measles	03 10 23	02 20 26					2				
Mumps	03 10 23	02 20 26					2				
Rubella	03 10 23	02 20 26					2				
Hepatitis A (Born on/after 1/1/06)	03 10 23	09 19 23					2				
Varicella	03 10 23	02 20 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	04 15 22	06 22 22	08 22 22				3				
HPV							0				
Influenza	11 28 22	01 03 23	09 19 23	09 06 24	10 03 25		5				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Susan G. Staviss MD
205 Hawkins Store Rd
Suite B-1
Kennesaw, GA 30144

Susan Staviss, MD 2/9/26

Certified by (Signature/Signature Stamp) **Date of Issue**

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

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: Matthew (first) Eshiozemede (middle) Obalo (last)

Child's Name: Emmanuel (first) Eshiozemede (middle) Obalo (last)

Parent/ Guardian Contact Information:

Daytime phone number: 678-510-3618
Evening phone number: 470-577-5107
Cell phone number: 678-510-3618

Date of Birth: 2/15/22 **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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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: 92.4cm Weight: 34.6lbs
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

2/20/26

Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

WELLSTAR NORTH COBB PEDIATRICS
205 HAWKINS STORE ROAD
KENNESAW, GEORGIA 30144
770-928-0862

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:

DPH Form 3300 Rev. 2013

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

OBALO, EMMANUEL ESHIOZEMEDE
Child's Name (Last name, First name)

02 | 15 | 2022
Birthdate

AGUOBA, ANTHONIA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2034
Date of Expiration

(Next required immunization or review of medical exemption due.)

[X] (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered.

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	04 15 22	06 22 22	08 22 22	06 16 23	02 20 26		5				
Polio	04 15 22	06 22 22	08 22 22	02 20 26			4				
Hepatitis B	02 15 22	04 15 22	06 22 22	08 22 22			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	04 15 22	06 22 22	06 16 23				3				
PCV (Under Age 5)	04 15 22	06 22 22	08 22 22	06 16 23			4				
Measles	03 10 23	02 20 26					2				
Mumps	03 10 23	02 20 26					2				
Rubella	03 10 23	02 20 26					2				
Hepatitis A (Born on/after 1/1/06)	03 10 23	09 19 23					2				
Varicella	03 10 23	02 20 26					2				
Recommended Vaccines (For Information Only)											
Rotavirus	04 15 22	06 22 22	08 22 22				3				
HPV							0				
Influenza	11 28 22	01 03 23	09 19 23	09 06 24	10 03 25		5				
Td (booster)							0				
Men-B							0				

Notes: A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Susan G. Staviss MD
205 Hawkins Store Rd
Suite B-1
Kennesaw, GA 30144

Susan Staviss, MD 2/9/26

Certified by (Signature/Signature Stamp) **Date of Issue**

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)


SOCIAL SECURITY
820-93-0953
THIS NUMBER HAS BEEN ESTABLISHED FOR
EMMANUEL ESHIOZEMEDE
OBALO
SIGNATURE
02/18/2022
USA

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Emmanuel
Name Suffix (Jr,II,III):
Legal Middle Name: Eshiozemede
Name Child is Called:
Legal Last Name: Obalo
Child's Social Security: 82093 - 0953 - Pending (30-Day Waiver) 02/16/2022
Gender: M [X] F [ ]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Iguoba
First Name: Anthonia
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: obalo.family@gmail.com
Zip Code: 30308

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [X] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[X] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[X] **English**

[ ] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [X] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [X] **No**

Briany Allen

Briany Allen — 2026-07-31

Parent/Guardian Signature **Date**

Matthew Obalo

EPP

INTERNAL REVENUE SERVICE 30144 - 0000-0

FORM AD-334
USDA
(REV. 8/17)

SOCIAL SECURITY NO.	PAY PERIOD DATE MO DA YR MO DA YR	P/P	T&A CONTACT POINT	ACCT. STAT.	ORGANIZATIONAL STRUCTURE	PERSNL OFFICE	PAY PLAN	GR.	STEP
-**-*	06/14/2026 06/27/2026	12	93-47-1620-12-11	0010	93-30-32-0033	2773	GS	12	02

SALARY	RATE	TYPE EMPL.	SCD FOR LEAVE	RET. DEDUCTIONS THIS APPOINTMENT
$97,809.00	PA	F/T	11/06/2023	$10,190.63

STATEMENT OF EARNINGS AND LEAVE

EARNINGS AND DEDUCTIONS

ITEM			HOURS			AMOUNT	
CODE		DESCRIPTION	P/P	YR. TO DATE		P/P	YR TO DATE
01		REGULAR TIME	39.00	931.00		1,827.93	43,582.85
61		ANNUAL LEAVE	25.00	71.50		1,171.75	3,346.98
62		SICK LEAVE	8.00	51.50		374.96	2,411.93
66		OTHER LEAVE	8.00	66.00		374.96	3,077.44
**	**	**** PAY PERIOD HOURS & GROSS PAY ****	80.00			3,749.60	52,419.20
75	02	RETIREMENT				164.98	2,306.42
75	15	TSP-FERS				187.48	4,452.27
76		SOCIAL SECURITY (OASDI)				232.48	3,250.04
77		FEDERAL TAX EXEMPTS MJ				105.92	1,254.52
78		ST TAX GA EXEMPTS M04				121.00	1,595.22
81		FEGLI- COVERAGE $ $100,000				16.00	223.68
88		CHKING/SAVING ********				250.00	3,500.00
88	40	TSP LOAN REPAY (FED)					480.45
88	40	TSP LOAN REPAY (FED)				117.80	471.20
88	40	TSP LOAN REPAY (FED)				117.80	589.00
97		MEDICARE TAX WITHHELD				54.37	760.08
99	52	TOP FED DELINQUENT DEBT				430.10	3,759.14
**	**	********** TOTAL DEDUCTIONS **********				1,797.93	22,642.02
**	**	********** NET PAY **********				1,951.67	29,777.18
**	**	DD/EFT ROUTING NO. ********					

YEAR TO DATE LEAVE STATUS

TYPE	ACCRUED	USED	BALANCE
CREDIT HOURS-BY PAY PERIOD			
RELIGIOUS COMP-BY PAY PERIOD			
TRAVEL COMP-BY PAY PERIOD			
MILITARY			
TIME OFF AWARD			
BPAPRA COMPENSATORY			
BPAPRA OBLIGATED DEBT			
DISABLED VETERAN LEAVE			

TYPE	1ST YEAR	2ND YEAR	3RD YEAR	BALANCE
REST. ANN. LEAVE HRS.				

YEAR TO DATE LEAVE STATUS

TYPE	ACCRUED	USED	BALANCE	PROJECTED USE OR LOSE	PT. HRS UNAPP	MAX. C/O
ANN	48.00	62.50	98.50			240 00
SICK	48	47.50	29.00			LEAVE CATEG
COMP						4

REMARKS

NAME AND ADDRESS

MATTHEW ESHIOZEMEDE
OBALO
3725 GEORGE BUSBEE
PKWY
APT 308
KENNESAW, GA 30144-0000

Official Pay Date 07/09/2026

AGENCY HR ADDRESS

IRS OGDEN PAYROLL CENTER
MAIL STOP 1502 P.O. 9774
OGDEN UT 84409
Phone 866-743-5748

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Partee, Jayden	**State Student ID:** 2609561
Date of Birth: 07/20/22	**Classroom:** Room 7
Parent / Guardian: RaShaye T. Partee (Jean) & Tavarus J. Partee	**Contact Phone:** 404-668-5290

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Partee_Jayden.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_f43234.pdf	11	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	178965048051888681511535382718 16.jpg	1	✓ VERIFIED
4	**Form 3231 (Georgia Certificate of Immunization)**	178965062977623254319008102296 79.jpg	1	✓ VERIFIED
5	**Child Social Security Card**	178965066599948222581783395161 1.jpg	1	✓ VERIFIED
6	**Certified Birth Certificate**	178965078359025835737825278072 2.jpg	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609561
Student Name: Partee, Jayden	**Date of Birth:** 07/20/22
Parent(s)/Guardian: RaShaye T. Partee (Jean) & Tavarus J. Partee	**Phone:** 404-668-5290

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ RECEIVED	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ RECEIVED	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ RECEIVED	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609561

Scan the QR code or click the link above. Use child's Date of Birth (**07/20/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:

Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**

**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Partee, Jayden** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box → 2026-27

Pre-K Registration Form School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	Kidazzle - Summit

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Partee			
CHILD'S FIRST NAME: Jayden			
CHILD'S MIDDLE NAME: Jamal	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 630-79-1216	D.O.B. (MM/DD/BY): 2022-07-2	SEX: ☑ M	F
HOME ADDRESS (*Do not enter PO Box Info*): 1915 Cornerstone Pass	COUNTY:		
CITY: Conyers	STATE: GA	ZIP: 30012	HOME PHONE: (404) 447-2416

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: Partee	FIRST: RaShaye		MIDDLE INITIAL: T
Home Address (*If different from child*): Same as Child			
City: Conyers	State: Ga	Zip: 30012	
Home Phone: (404) 447-2416	Cell Phone: ( ) 404-447-2416		
Email Address: rashayej@yahoo.com			
Place of Employment: Emory Healthcare	Work Phone: ( ) 404-686-2570		
Address: 550 Peachtree St. NW			
City: Atlanta	State: Ga	Zip: 30308	
Parent/Guardian #2 - LAST NAME: Partee	FIRST: Tavarus		MIDDLE INITIAL: J
Home Address (*If different from child*): SAME			
City: Conyers	State: Ga	Zip: 30012	
Home Phone: (678) 791-6127	Cell Phone: ( ) 678-791-6127		
Email Address: tavarusp@gmail.com			
Place of Employment: Coca-Cola	Work Phone: ( )		
Address: 4913 Mason Rd			
City: Atlanta	State: Ga	Zip: 30349	

EMERGENCY CONTACT INFORMATION **(Persons to contact in the event that either parent/guardian cannot be contacted)**

	NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.	Lechell Harris	Grandmother	404-447-3986		lechell210@yahoo.com
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.

RaShaye Jean

Signature Parent/Guardian: RaShaye Partee **DATE:** 2026-08-04

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. RaShaye Partee	1915 Cornerstone Pass Conyers, Ga	Mother	
2. Tavarus Partee	1915 Cornerstone Pass Conyers, Ga	Father	
3. Lechell Harris	202 Pine Street NW Atlanta, Ga		
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Chaudhari Rajani

DATE OF LAST FULL HEALTH SCREENING: 2025-11-20 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:

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-05 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Jayden Jamal Partee

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑**Breakfast** ☑**Lunch** ☑**Afternoon Snack** ☑**Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

RaShaye Jean

Parent/Guardian Signature: RaShaye Parker

Date: 2026-08-04

Facility Administrator Signature: K. Harris

Date: 8/4/2026

Georgia Dept of Early Care and Learning
ARIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-08-04

CHILD INFORMATION:

Legal First Name: Jayden		Name Suffix (Jr,II,III):
Legal Middle Name: Jamal		Name Child is Called:
Legal Last Name: Partee		
Child's Social Security #: 630-79-1216	DOB (M/D/Y): 2022-07-20	Gender: M ☑ F
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): 2026-08-04	

PARENT/GUARDIAN INFORMATION:

Last Name: Partee	First Name: RaShaye	
Relationship: Mother ☑ Father	Grandparent	Guardian Other
Email Address: rashayej@yahoo.com	Zip Code: 30012	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino ☑ **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

___ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English)?

RaShaye Jean

RaShaye Parker

Parent/Guardian Signature

4. Was your child born as a:

☑ **Single Birth (1)**

Twin (2)

Triplet (3)

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

___ **Yes** ___ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

___ **Childcare and Parent Services (CAPS)**

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

Supplemental Nutrition Assistance Program (SNAP)

Medicaid

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** **No**

2026-08-04

Date

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.

RaShaye Jean

SIGNATURE (Parent/Guardian): RaShaye Partee

DATE: 2026-08-04

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, Jayden Partee, 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 RaShaye Jean

SIGNATURE (Parent/Guardian): RaShaye Partee

DATE: 2026-08-04

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:

(i.) Provide information about the benefits of regular attendance.

(ii.) Support families to promote the child's regular attendance.

(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,

(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email:** karenharris@kidazzle.com
  (Leave your name, child name and reason for absentee or lateness)

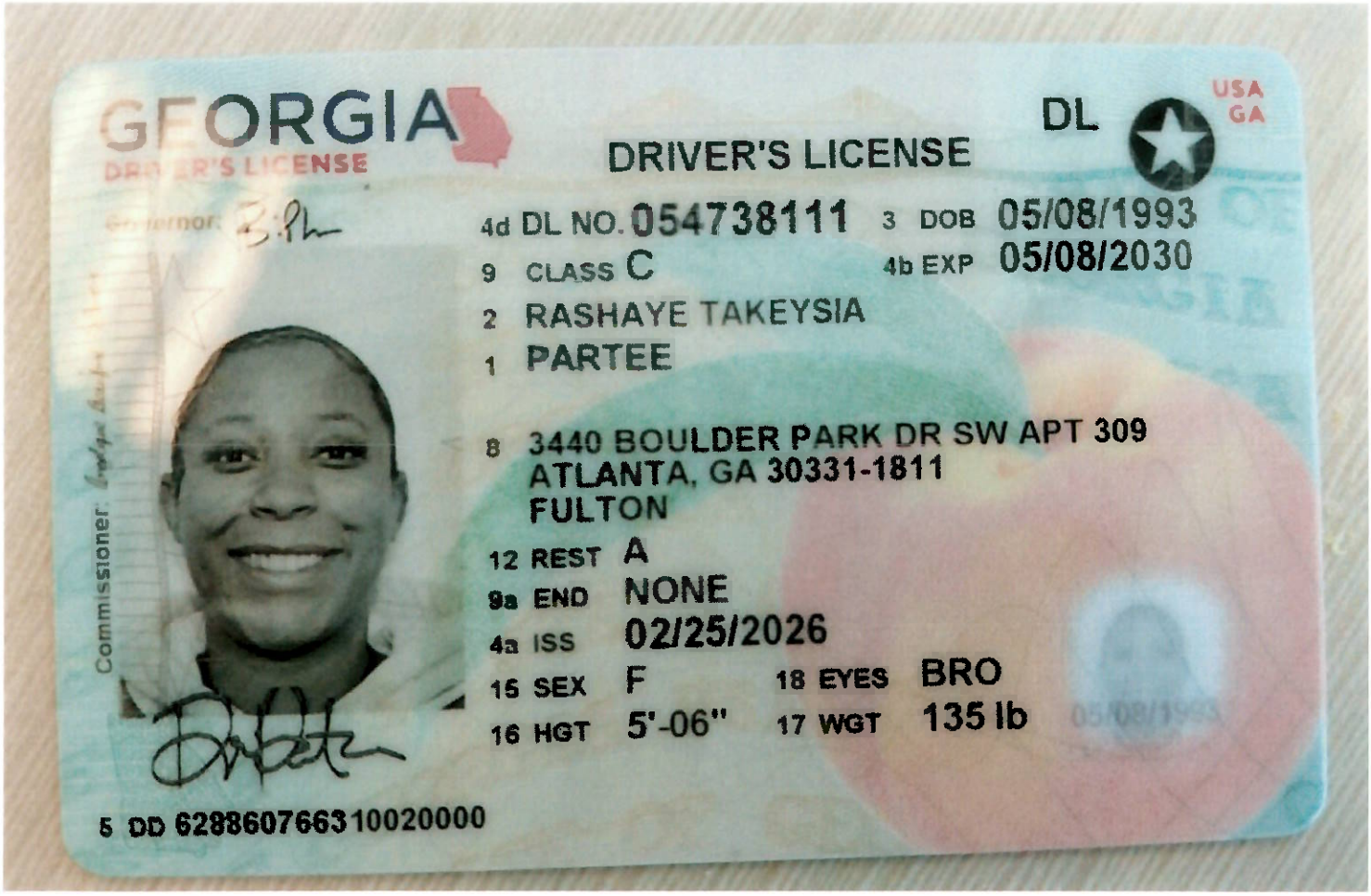
If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

RaShaye Jean

Parent(s) or Guardians Signature: RaShaye Parker **Date:** 2026-08-04

Administrative Signature: K. Harris **Date:** 8/4/20

Teacher Signature: _____ **Date:** _____


GEORGIA
DRIVER'S LICENSE
DL
USA
GA
4d DL NO. 054738111
3 DOB 05/08/1993
9 CLASS C
4b EXP 05/08/2030
2 RASHAYE TAKEYSIA
1 PARTEE
8 3440 BOULDER PARK DR SW APT 309
ATLANTA, GA 30331-1811
FULTON
12 REST A
9a END NONE
4a ISS 02/25/2026
15 SEX F
18 EYES BRO
16 HGT 5'-06"
17 WGT 135 lb
5 DD 628860766310020000
Commissioner

GEORGIA
DRIVER'S LICENSE

USA
GA

CDL

COMMERCIAL DRIVER'S LICENSE

Governor:



Commissioner:

4d DL NO. 056877701 3 DOB 10/17/1991
9 CLASS A 4b EXP 10/17/2032
2 TAVARUS JAMAL
1 PARTEE

8 3440 BOULDER PARK DR SW APT 309
ATLANTA, GA 30331-1811
FULTON

12 REST B,E
9a END NONE
4a ISS 06/11/2024
15 SEX M 18 [illegible]TS BRO
16 HGT 5'-11" 17 WGT 165 lb

5 DD 566497760790020000

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH	Death Number	Local File Number	1. State File Number
			2022GA000067138

3. CHILD'S NAME: FIRST 5. MIDDLE 4. LAST 5. JR., III, ETC.	6. SEX (M or F)	7. DATE OF BIRTH (Mo., Day, Year)
JAYDEN JAMAL PARTEE	MALE	07/20/2022

8. TIME OF BIRTH	9. TYPE BIRTH (Single, Twin, Triplet, Etc.)	10. IF NOT SINGLE SPECIFY BIRTH ORDER
22:46 MILITARY	SINGLE	

11. CITY, TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital, give street and Number.)
ATLANTA	EMORY UNIVERSITY HOSPITAL MIDTOWN
13. IF NOT HOSPITAL, Specify	**14. COUNTY OF BIRTH**
	FULTON

15. MOTHER'S NAME: FIRST 16. MIDDLE 17. LAST	18. MAIDEN (Last Name)
RA'SHAYE TA'KEYSIA JEAN	JEAN

19. DATE OF BIRTH (Month, Day, Year)	20. STATE OF BIRTH (If not U.S.A., Name Country)	21. RESIDENCE - STATE	22. COUNTY
06/08/1993	FLORIDA	GEORGIA	FULTON

23. CITY, TOWN OR LOCATION	24. STREET AND NUMBER OF RESIDENCE
ATLANTA	3440 BOULDER PARK DRIVE SW 309

25. MOTHER'S MAILING ADDRESS	26. RESIDENCE INSIDE CITY LIMITS? (yes or No)
3440 BOULDER PARK DRIVE SW 309 ATLANTA GEORGIA 30331	YES

27. FATHER'S NAME: FIRST 28. MIDDLE 29. LAST, JR., ETC.	30. DATE OF BIRTH (Month, Day, Year)	31. STATE OF BIRTH (If not U.S.A., Name Country)
TAVARUS JAMAL PARTEE	10/17/1991	GEORGIA

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
RA'SHAYE T JEAN	MOTHER	YES

34. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature) Electronically signed by	35. DATE SIGNED (Mo., Day, Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
/S/ CAROLYN BASS	07/21/2022	(Name) JADE STAFFORD 37. (Title) MD

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO.	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town, State, Zip)
(Name) CAROLYN BASS (Title) BIRTH RECORD CLERK		550 PEACHTREE STREET NE, ATLANTA GEORGIA 30308

41. REGISTRAR (Signature) Electronically signed by	42. DATE RECEIVED BY STATE REGISTRAR (Mo., Day, Year)
/S/ CYNTHIA M. BUSKEY	07/22/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE — Form 3901A (Rev. 01/2013)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept records clearly embossed with Chapter 31-10, Code of Georgia as amended.

10421493

Cynthia M. Buskey
State Registrar

Sheila V. Lewis
County Registrar

C8489030

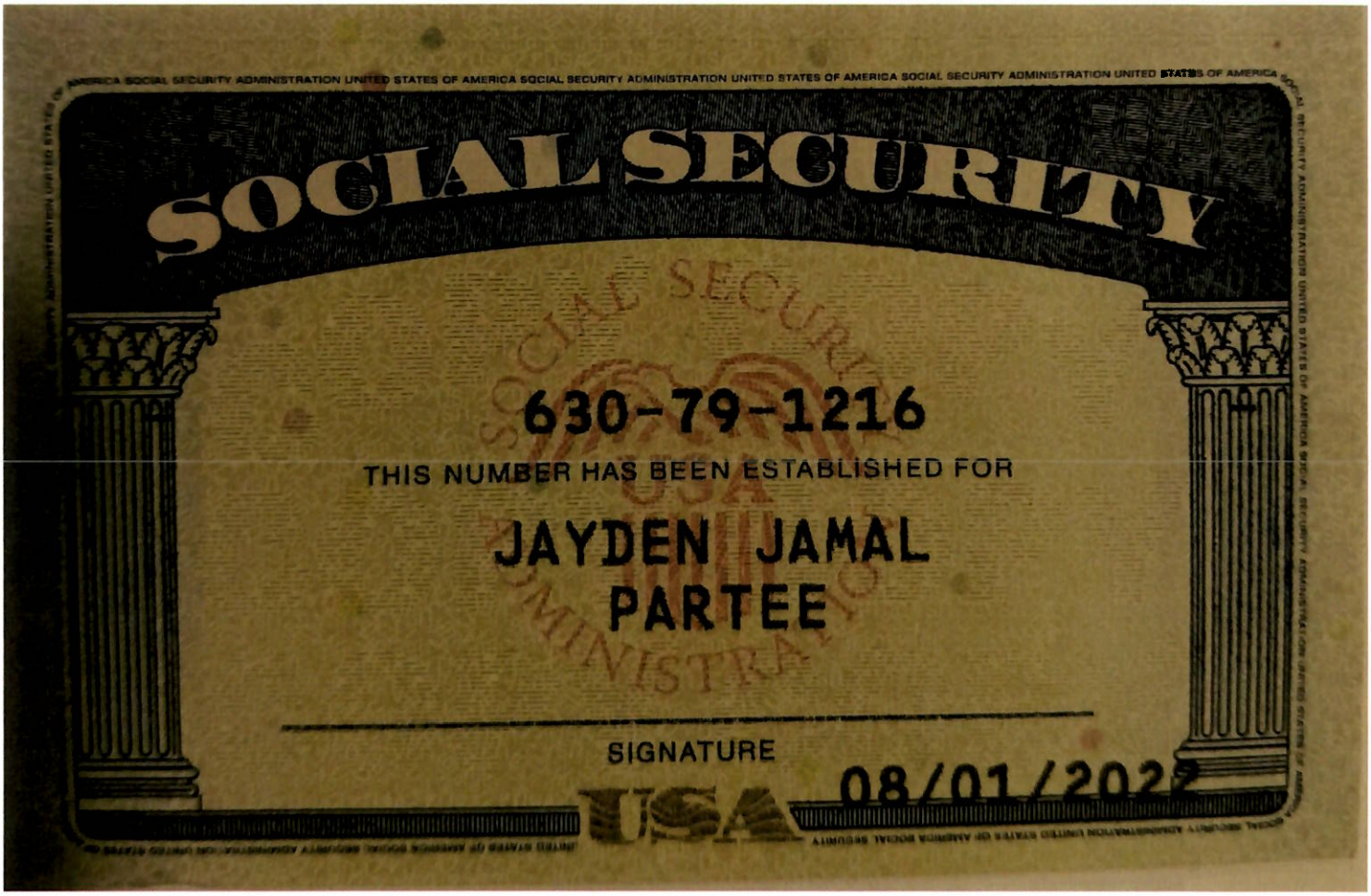
WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

AUG 14 2024

VOID IF ALTERED OR COPIED

VOID IF ALTERED OR ERASED

Form 3972 (Rev. 5/15)


SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA
SOCIAL SECURITY
630-79-1216
THIS NUMBER HAS BEEN ESTABLISHED FOR
JAYDEN JAMAL
PARTEE
SIGNATURE
08/01/2022
USA

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/ Guardian Name: RASHAYE (first) JEAN (middle) [illegible] (last)

Parent/ Guardian Contact Information:
Daytime phone number: 4044472416
Evening phone number:
Cell phone number:

Child's Name: JAYDEN (first) [illegible] (middle) PARTEE (last)

Date of Birth: 07/20/2022 **Gender:** ☐Male ☒Female

Child's Home Address:
3OULDER PARK DR SW AF (street) Atlanta (city) GA (state) 30331 (zip code) [illegible] (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

11/20/2025
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
Anjali Chaudhari, DO
402 North Avenue NE, Atlanta, GA, 30308

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

11/20/2025
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
Anjali Chaudhari, DO
402 North Avenue NE, Atlanta, GA, 30308

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

11/20/25
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
RAJANI CHAUDHARI MD PC
402 NORTH AVENUE NE
ATLANTA GA 30308

NUTRITION
- ☐ Unable to screen (explain why below)

Height: 38.5 inc Weight: 34 lbs.
BMI: 16.13 BMI%: 66

- ☒ 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

11/20/2025
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
Anjali Chaudhari, DO
402 North Avenue NE, Atlanta, GA, 30308

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:

DPH Form 3300 Rev. 2013

Rev. 07/2020

Georgia Department of Public Health

Form **3231**

CERTIFICATE OF IMMUNIZATION

PARTEE, JAYDEN JAMAL
Child's Name (Last name, First name)

07 | 20 | 2022
Birthdate

JEAN, RA'SHAYE TA'KEYSIA
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or review of medical exemption due.)

☐ (Fill in X)
Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

☐ (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

☐ (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	09 28 22	11 21 22	02 07 23	11 08 23			4				
Polio	09 28 22	11 21 22	02 07 23				3				
Hepatitis B	07 20 22	09 28 22	11 21 22	02 07 23			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	09 28 22	11 21 22	02 07 23	08 08 23			4				
PCV (Under Age 5)	11 21 22	02 07 23	05 08 23	08 08 23			4				
Measles	08 08 23						1				
Mumps	08 08 23						1				
Rubella	08 08 23						1				
Hepatitis A (Born on/after 1/1/06)	08 08 23	02 08 24					2				
Varicella	08 08 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus	09 28 22	11 21 22					2				
HPV							0				
Influenza	11 08 23	02 08 24					2				
Td (booster)							0				
Men-B							0				

Notes:
A licensed Georgia physician, **Advanced Practice Registered Nurse, Physician Assistant,** qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. **When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.**

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Rajani Chaudhari MD
402 North Ave NE
404-873-1894
Atlanta, GA 30308-2504

Certified by (Signature/Signature Stamp)

11 2023
Date of Issue

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRIT

her side contains important

below the signature line.

YOUR SOCIAL SECURITY CARD

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.





CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number | Local File Number | 1. State File Number: 2022GA000067138

2.CHILD'S NAME: FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC.: JAYDEN JAMAL PARTEE

6.SEX (M or F): MALE

7.DATE OF BIRTH (Mo.,Day,Year): 07/20/2022

8.TIME OF BIRTH: 22:45 MILITARY

9. THIS BIRTH (Single, Twin, Triplet, Etc.): SINGLE

10.IF NOT SINGLE SPECIFY BIRTH ORDER:

11.CITY,TOWN, OR LOCATION OF BIRTH: ATLANTA

12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.): EMORY UNIVERSITY HOSPITAL MIDTOWN

13. IF NOT HOSPITAL,Specify:

14. COUNTY OF BIRTH: FULTON

15. MOTHER'S NAME FIRST 16. MIDDLE 17.LAST: RA'SHAYE TA'KEYSIA JEAN

18.MAIDEN (Last Name): JEAN

19.DATE OF BIRTH (Month,Day,Year): 05/08/1993

20.STATE OF BIRTH (If not U.S.A.,Name Country): FLORIDA

21.RESIDENCE - STATE: GEORGIA

22. COUNTY: FULTON

23. CITY,TOWN OR LOCATION: ATLANTA

24.STREET AND NUMBER OF RESIDENCE: 3440 BOULDER PARK DRIVE SW 309

25.MOTHER'S MAILING ADDRESS: 3440 BOULDER PARK DRIVE SW 309 ATLANTA GEORGIA 30331

26.RESIDENCE INSIDE CITY LIMITS? (yes or No): YES

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.: TAVARUS JAMAL PARTEE

30.DATE OF BIRTH (Month,Day,Year): 10/17/1991

31.STATE OF BIRTH(If not U.S.A. ,Name Country): GEORGIA

32a. INFORMANT'S NAME (Type or Print): RA'SHAYE T JEAN

32b. RELATION TO CHILD: MOTHER

33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No): YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature) Electronically signed by: /S/ CAROLYN BASS

35. DATE SIGNED (Mo.,Day,Year): 07/21/2022

36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print) (Name): JADE STAFFORD

37.(Title): MD

38. CERTIFIER (Type or Print) (Name): CAROLYN BASS (Title): BIRTH RECORD CLERK

39. PHYSICIAN'S MEDICAL LIC. NO.:

40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip): 550 PEACHTREE STREET NE, ATLANTA GEORGIA 30308

41. REGISTRAR (Signature) Electronically signed by: /S/ CYNTHIA M. BUSKEY

42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year): 07/22/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE Form 3901A (Rev. 01/2013)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept documents clearly embossed per Chapter 31-10, Code of Georgia as amended.

10421493

State Registrar

County Registrar

C8489030

WARNING: AUG 14 2024

THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

VOID IF ALTERED OR COPIED

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Taylor, Elijah Samuel	**State Student ID:** 2639874
Date of Birth: 08/23/22	**Classroom:** Room 4
Parent / Guardian: Christopher Taylor	**Contact Phone:** 407-784-5811

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (5 PENDING)
Remaining items needed for 100% compliance: **Child Certified Birth Certificate; Proof of GA Residency; Form 3231 (Immunization Certificate); Form 3300 (Screening Certificate); Parent Photo ID**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Taylor_Elijah_Samuel.pdf	1	✓ OFFICIAL
2	**Registration Application**	Ga_Full_Prek_App_2026_2027_-_Template (6).pdf	11	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 4 • **State ID:** 2639874
Student Name: Taylor, Elijah Samuel	**Date of Birth:** 08/23/22
Parent(s)/Guardian: Christopher Taylor	**Phone:** 407-784-5811

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
[ACTION NEEDED]	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
[ACTION NEEDED]	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
[ACTION NEEDED]	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2639874

Scan the QR code or click the link above. Use child's Date of Birth (**08/23/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:

Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**

**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Taylor, Elijah Samuel** Parent Signature: _____ Date: _____



Pre-K School Registration Information
2025-2026

Complete the attached Pre-K Registration Form

- ☐ Birth Certificate – **SUBMIT IMMEDIATELY**
- ☐ Social Security Card -**SUBMIT IMMEDIATELY**
- ☐ Proof of Residence (Lease, Light Bill, or Notarized Letter) – **SUBMIT IMMEDIATELY**
- ☐ Parent/ Guardian's Picture ID (Driver's License/State Identification Card, etc.)- **SUBMIT IMMEDIATELY**
- ☐ Proof of Income (12 months of previous year check stubs, Award Letter, W-2, Tax return, SSI Letter, SNAP Letter, etc.)

  (If married we need both parents' income.) -**SUBMIT IMMEDIATELY**

***PLEASE BE AWARE THAT ALL HIGHLIGHTED ITEMS ABOVE ARE NEEDED IN ORDER FOR YOUR CHILD TO BEGIN THE SCHOOL YEAR!!!! THERE MAY ALSO BE ADDITIONAL PAPERWORK FOR REGISTRATION TO BE COMPLETED.**

Begin gathering all the documents below to complete your child's file:

- ☐ Insurance Card (Medicaid, Blue Cross, Humana, Aetna, etc.)
- ☐ Current Physical Exam (**Must be within a year, blood pressure, hematocrit, and lead MUST be recorded on form**)
- ☐ Ear, Eye, and Dental Form 3300 **SUBMIT IMMEDIATELY**
- ☐ Dental Exam (Form 5)
- ☐ Immunization (Shot) Record Form 3231 **SUBMIT IMMEDIATELY**

If you have any additional questions, please contact Ms. Harris at (404)-753-8884/404-753-8030 (O) or (404) 884-1483 (M). You can also email documents in at karenharris@kidazzle.com.

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box →

Pre-K Registration Form

2025/2026 **School Year**

PROVIDER LEGAL NAME: KIDazzle childcare	(This section to be completed by the provider)
SCHOOL/SITE NAME: KIDazzle childcare	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Taylor			
CHILD'S FIRST NAME: Elijah			
CHILD'S MIDDLE NAME: Samuel	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 003239581	D.O.B. (MM/DD/BY): 2022-08-2	SEX: ☑ M ☐ F	
HOME ADDRESS (*Do not enter PO Box Info*): 2518 Lester st	COUNTY:		
CITY: East Point	STATE: GA	ZIP: 30344	HOME PHONE: (407)845811

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: Taylor	FIRST: Christopher		MIDDLE INITIAL: C
Home Address (*If different from child*): 2518 Lester st			
City: East point	State: Ga	Zip: 30344	
Home Phone: (407)845811	Cell Phone: ( ) NA		
Email Address: Christophertaylor.mail@gmail.com			
Place of Employment: PHACON Inc	Work Phone: ( ) NA		
Address: 2801 Buford hwy ne			
City: Brookhaven	State: Ga	Zip: 30329	
Parent/Guardian #2 - LAST NAME: Taylor	FIRST: Ashely		MIDDLE INITIAL: C
Home Address (*If different from child*): 2518 Lester st			
City: East Point	State: Ga	Zip: 30344	
Home Phone: (407)7849465	Cell Phone: ( )NA		
Email Address: NA			
Place of Employment: TLC	Work Phone: ( )NA		
Address: 2518 Lester st			
City: East point	State: Ga	Zip: 30344	

EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)

	NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.	Na	Na	Na		Na
2.	Na	Na	Na		Na

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.

Christopher Taylor

Signature Parent/Guardian: Christopher Taylor **DATE:** 2026-09-08

Document Ref: 331F19F0-FE9D-453A-9AD9-633E6DDDB39C

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.	NA	Na	Na	
2.	Na	Na	Na	
3.	Na	Na	Na	
4.	Na	Na	Na	

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Na .

DATE OF LAST FULL HEALTH SCREENING: 2026-01-01 PHONE: (Na)

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

Na

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

Na

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:

Na

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-09-08 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Elijah Taylor
_____
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After Schoo Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: 0$

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑**Breakfast** ☑**Lunch** ☑**Afternoon Snack** ☑**Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Christopher Taylor

Parent/Guardian Signature: Christopher Taylor

Date: 2026-09-08

Facility Administrator Signature: _____

Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-09-08		
CHILD INFORMATION:		
Legal First Name: Elijah		Name Suffix (Jr,II,III):
Legal Middle Name: Samuel		Name Child is Called:
Legal Last Name: Taylor		
Child's Social Security # ___-___-003239581	DOB (M/D/Y): 2022-08-27	Gender: M ☑ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): 2026-09-08	
PARENT/GUARDIAN INFORMATION:		
Last Name: Taylor	First Name: Christopher	
Relationship: Mother ☐ Father ☑	Grandparent ☐ Guardian ☐ Other ☐	
Email Address: Christophertaylor.mail@gmail.com	Zip Code: 30344	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☑ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English)?

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

Christopher Taylor

Christopher Taylor

Parent/Guardian Signature

2026-09-08

Date

Document Ref: 331F19F0-FE9D-453A-9AD9-633E6DDDB39C

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.

Christopher Taylor

SIGNATURE (Parent/Guardian): Christopher Taylor

DATE: 2026-09-08

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, Elijah Taylor, 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: Christopher Taylor

SIGNATURE (Parent/Guardian): Christopher Taylor

DATE: 2026-09-08

Document Ref: 331F19F0-FE9D-453A-9AD9-633E6DDDB39C

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
   (i.) Provide information about the benefits of regular attendance.
   (ii.) Support families to promote the child's regular attendance.
   (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
   (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Christopher Taylor

Parent(s) or Guardians Signature: Christopher Taylor **Date:** 2026-09-08

Administrative Signature: _____ Date: _____

Teacher Signature: _____ Date: _____

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Christopher Taylor	SNAP, TANF or FDPR	☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

Child Income/How often? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Christopher Taylor	$ 30,000 per year	$ Earnings/_____	$ _____/_____	$ _____/_____
2. First and Last Name	$ Earnings/_____	$ Earnings/_____	$ _____/_____	$ _____/_____
3. First and Last Name	$ Earnings/_____	$ Earnings/_____	$ _____/_____	$ _____/_____
4. First and Last Name	$ Earnings/_____	$ Earnings/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX 0808 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday ☑ Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday Saturday ☐

Circle the meals your child will normally receive while in care: ☑ Breakfast ☑ AM Snack ☑ Lunch ☑ PM Snack ☐ Supper ☐ Evening Snack

PART IV: Signature

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care.* ***If not completed fully and signed, the participant will be placed in the Paid category.***

Signature: X _____ **Print Name:** Christopher Taylor **Date:** 2026-09-0

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per**: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size**: _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility**: check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date**: _____

Confirming Official's Signature: _____ **Date**: _____

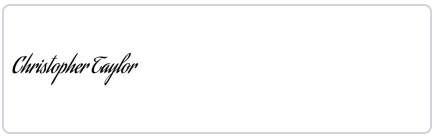
Follow Up Official's Signature: _____ **Date**: _____

12/2022

Signature Certificate

Reference number: 331F19F0-FE9D-453A-9AD9-633E6DDDB39C

Sent on **September 8, 2026 10:15 PM UTC**

Signed By	Signature
Christopher Taylor christophertaylor.mail@gmail.com Viewed: September 8, 2026 10:15 PM UTC Signed: September 8, 2026 10:32 PM UTC	 IP address: 2607:fb92:180:c67f::3409 Location: Riverdale, US

Document completed by all parties on
September 8, 2026 10:32 PM UTC

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Tolbert, Gianna Jade	**State Student ID:** 2609505
Date of Birth: 07/07/22	**Classroom:** Room 7
Parent / Guardian: Alana Richter	**Contact Phone:** 404-394-1182

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Tolbert_Gianna_Jade.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_96d8d5.pdf	15	✓ ON FILE
3	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	Gianna_Tolbert_Dental_3300.pdf	1	✓ VERIFIED
4	**Head Start Physical Exam (Form #78)**	Tolbert, Gianna Jade - Head Start Physical Exam.pdf	1	✓ VERIFIED
5	**Form 3300 (Screening Certificate)**	Tolbert, Gianna Jade - Form 3300 Screening Certificate.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609505
Student Name: Tolbert, Gianna Jade	**Date of Birth:** 07/07/22
Parent(s)/Guardian: Alana Richter	**Phone:** 404-394-1182

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609505
Scan the QR code or click the link above. Use child's Date of Birth (**07/07/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Tolbert, Gianna Jade** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box →

Pre-K Registration Form

2026-27 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDazzle - Summit

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: tolbert			
CHILD'S FIRST NAME: gianna			
CHILD'S MIDDLE NAME: jade	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 279614088	D.O.B. (MM/DD/BY): 2022-07-C	SEX:	M ☑ F
HOME ADDRESS (*Do not enter PO Box Info*): 8107 Peachford Circle	COUNTY:		
CITY: atlanta	STATE: GA	ZIP: 30338	HOME PHONE: (2295665363

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: richter	FIRST: alana	MIDDLE INITIAL: c
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( ) 2295665363	
Email Address: alanacrichter@gmail.com		
Place of Employment: Emory Midtown	Work Phone: ( )	
Address:		
City: atlanta	State: ga	Zip: 30308
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.	shlonda	grandmther	2294253824		shlondam@gmail.co
2.	~~tiecoy~~ thalayna rhodes	aunt	6786292351		m

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.

Alana Richter

Signature Parent/Guardian: Alana Richter **DATE:** 2026-04-27

Document Ref: BC38C188-AB56-4D63-8A48-DA1CFD2B5A33

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:

Document Ref: BC38C188-AD90-4D03-8A48-DA1CFD2B5A33

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-04-27 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

gianna tolbert

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After School Program Pay: _____ Sponsor Pay: _____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑ **Breakfast** ☑ **Lunch** ☑ **Afternoon Snack** ☑ **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Alana Richter

Parent/Guardian Signature: Alana Richter

Date: 2026-04-27

Facility Administrator Signature: Karen Hans

Date: 7/8/26

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.

Alana Richter

SIGNATURE (Parent/Guardian): Alana Richter

DATE: 2026-04-27

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, gianna tolbert, 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 Alana Richter

SIGNATURE (Parent/Guardian): Alana Richter

DATE: 2026-04-27

Document Ref: BC38C188-AD90-4D03-8A48-DA1CFD2B5A33

Georgia Dept of Early Care and Learning

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-04-27		
CHILD INFORMATION:		
Legal First Name: gianna		Name Suffix (Jr,II,III):
Legal Middle Name: jade		Name Child is Called:
Legal Last Name: tolbert		
Child's Social Security # 279614088	DOB (M/D/Y): 2022-07-07	Gender: M F ☑
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): 2026-04-27	
PARENT/GUARDIAN INFORMATION:		
Last Name: richter	First Name: alana	
Relationship: Mother ☑ Father	Grandparent Guardian	Other
Email Address: alanacrichter@gmail.com	Zip Code: 30338	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino ☑ **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☑ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Alana Richter

Alana Richter

Parent/Guardian Signature

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

Yes ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☑ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

Yes ☑ **No**

2026-04-27

Date

Document Ref: BC38C188-AD90-4D03-8A48-DA1CFD2B5A33



HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.
   1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**
   2) A program must implement strategies to promote attendance. At minimum, a program must:
      (i.) Provide information about the benefits of regular attendance.
      (ii.) Support families to promote the child's regular attendance.
      (iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
      (iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.
   3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email:** karenharris@kidazzle.com
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Alana Richter

Parent(s) or Guardians Signature: Alana Richter **Date:** 2026-04-27

Administrative Signature: K. Harris **Date:** 7/8/24

Teacher Signature: _____ **Date:** _____

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Alana Richter

Parent(s) or Guardians Signature: Alana Richter **Date:** 2026-04-27

Administrative Signature: K. Harris **Date:** 7/8/24

Teacher Signature: _____ **Date:** _____

G. Tolbert

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
tolbert gianna j	SNAP, TANF or FDPIR	☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
Last, First and Middle Initial		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. alana richter	$30000 /_____	$_____/_____	$_____/_____	$_____/_____
2. First and Last Name	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. First and Last Name	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. First and Last Name	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.

Last four Digits of Social Security Number XXX-XX 5419 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday ☑ Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday Saturday

Circle the meals your child will normally receive while in care: ☑ Breakfast ☑ AM Snack ☑ Lunch ☑ PM Snack Supper Evening Snack

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category

Signature: X _____ **Print Name:** alana richter **Date:** 2026-04-2

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only.*

Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.

Check (✓) one ethnic identity:	Check (✓) one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility:** check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow Up Official's Signature: _____ **Date:** _____

12/2022

GEORGIA
DRIVER'S LICENSE

USA
GA

DL

DRIVER'S LICENSE

Governor:



Commissioner:

4d DL NO. 058789607 3 DOB 06/22/1998
9 CLASS C 4b EXP 06/22/2029
2 ALANA CHEYENNE
1 RICHTER

8 828 STORY ST
ASHBURN, GA 31714-4111
TURNER

12 REST A
9a END NONE
4a ISS 12/03/2024
15 SEX F 18 EYES BRO
16 HGT 5'-02" 17 WGT 140 lb

5 DD 583915363570020000

DEPARTMENT OF VETERANS AFFAIRS

July 06, 2026

Alana Cheyenne Richter
8107 Peachford Cir
Dunwoody, GA 30338

Dear Alana Richter:

This letter certifies that Alana Cheyenne Richter is receiving service-connected disability compensation from the Department of Veterans Affairs.

The current benefit paid is as follows:

Gross Benefit Amount	$4,555.38
Net Amount Paid	$4,555.38
Effective Date	December 1, 2025
Combined Evaluation	100 percent

How You Can Contact Us

- If you need general information about benefits and eligibility, please visit us at https://www.va.gov.
- Call us at 1-800-827-1000.
- Contact us using Telecommunications Relay Services (TTY) at 711 24/7.
- Send electronic inquiries through the Internet at https://www.va.gov/contact-us.

Sincerely Yours,

Regional Office Director

AR 8/28/2025

LEASE AGREEMENT FOR Camden Dunwoody COMMUNITY			
Unit Address (the "Unit") 8107 Peachford Cir Dunwoody,GA 30338-6530 Community address: 10 Peachford Cir Dunwoody, GA 30338-6416		Mailbox Number 235	Contract Date 08/26/2025
Monthly Rent $ 2067.00	Prorated Rent $ 266.72	Prepared By: Forest Carpenter	

Utilities and Other Services included in the Monthly Rent: The following items are included in the Monthly Rent identified above, if checked:

☐ water ☐ electricity ☐ wastewater ☐ gas ☐ trash ☑ front door trash pickup ☐ homeowners/business association fees ☐ pest control ☑ Technology Package (which may include cable TV, internet and Wi-Fi)

Resident agrees to pay for all items not checked above to the extent allowed by applicable law and as provided in this Lease or any other document signed by Resident.

Additional Items: The following items are included in the Monthly Rent identified above:
N/A

(if any rentable item is separately identified and subject to sales tax, Resident shall pay sales tax in addition to the charge for the item)

Special Provisions: Additional addenda attached. N/A

LEASE TERM				
Type Transfer	**Length** 14	**Start Date** 08/28/2025	**End Date** 10/25/2026	**Date Signed** 8/28/2025

POTENTIAL CHARGES					
NSF	$25.00	Termination Charge	$2067.00	Late Payments	Rent is late on day 4. The late fee is 10.00% + 0.00 per day.
Access Gate/Remote	$50.00	Cancellation Payment	$2067.00	Transfer Fee	50% of Monthly Rent

MONTHLY PAYMENT	
Rent	1899.00
Technology Package	117.00
Front Door Trash Pickup	36.00
Parking Monthly Rent Charge	15.00
TOTAL MONTHLY PAYMENT	**$2067.00**

DEPOSITS	
Security Deposit	$0.00
Animal Deposit	$
TOTAL DEPOSITS	**$N/A**

ONE-TIME FEES	
Application Fee(s)	$0.00
Administrative Fee	$
Community Fee	$75.00
Non-Refundable Animal Fee(s)	$0
Clean Fee	$175 1 Bedroom/$200 2 Bedroom/$225 3 Bedroom

RESIDENT NAME(S):
Alana Richter

OCCUPANT(S):
Alana Richter, Gianna Ross, DeCarlos Collier

Owner's Agent Initials _____

Unless otherwise indicated, capitalized terms used in this document shall refer to those terms identified above.

AR 8/28/2025

© Camden, 2005 Revised April 2025

This Lease Agreement (this "Lease", which term shall include this document, the State Addendum attached to this document and all other applicable addenda referred to in this document or executed by the Resident identified herein) is made and entered into on 08/26/2025, by and between Camden Dunwoody (the "Owner"), the owner of the Camden Dunwoody apartment community (the "Community") by and through Camden Development, Inc., as Owner's managing agent only and not as principal, and the Residents identified on page 1 ("Resident", whether one or more) upon the terms and conditions stated herein. If there is more than one Resident, all persons identified on page 1 as Residents are jointly and severally liable for all payments and other obligations under this Lease. **The State Addendum modifies and adds certain provisions to this document. This document and the State Addendum should be read together and carefully.** When there is a conflict between this document and the State Addendum, the State Addendum controls. For and in consideration of the mutual promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by all parties, the parties agree as follows:

1. ***Delivery of Unit.***

a. Resident's Obligations when Lease is signed. Once Resident signs this Lease, Resident shall be

Turner County, Georgia
Turner Superior Court
Filed October 13, 2023
Mary Lee Green
Mary Lee Green, Clerk

IN THE SUPERIOR COURT OF TURNER COUNTY
STATE OF GEORGIA

SHANNON DAVID TOLBERT,	§	
	§	
Plaintiff,	§	
v.	§	**Civil Action No. 2023-CV-0078**
	§	
ALANA CHEYENNE RICHTER,	§	
	§	
Defendant.	§	

FINAL ORDER OF LEGITIMATION & CUSTODY

The parties are the parents of Gianna Jade Ross, a female child born outside of wedlock 2022. Plaintiff filed his pro se Petition for Legitimation, Custody, and/or Visitation on July 12, 2023. Upon hearing from both parties on October 10 & 13, 2023, IT IS HEREBY ORDERED as follows:

Legitimation

Finding it in her best interest, Gianna Jade Ross (hereinafter, referenced as "Gianna") is hereby declared the legitimate child of Shannon David Tolbert for all intents and purposes under law as fully if she were born in lawful wedlock of the parties. Gianna may inherit for Plaintiff, and Plaintiff from Gianna. Gianna's name shall be changed and hereafter she shall be known as "Gianna Jade Tolbert".

Custody & Visitation

1. Legal Custody: The parties shall have joint legal custody of Gianna, governed by the following provisions:

(a) It is the Court's intention for the parties to have a full and active role in providing a sound, moral and healthy environment for Gianna. Each party shall have the right to make decisions regarding Gianna's day to day care while she is in the custody of such party, including any emergency decisions affecting her health or safety. The parties shall use their best efforts to work together in a manner consistent with Gianna's best interest and shall consult with one another on issues regarding the child. If the parties are unable to agree on any issue regarding COUNTY Defendant shall have the final decision-making authority.

GEORGIA, Turner County, I, Mary Lee Green, Clerk of Superior Court, Turner County, Georgia hereby certify that the within and foregoing page(s) contain(s) a true and correct copy as appears of record in said office.

Given under my official signature and the seal of said Court, this 13th day of October 2023

Mary Lee Green
Clerk Superior Court, Turner County, Ga.

Rev. 07/2020

Georgia Department of Public Health

Form 3231

CERTIFICATE OF IMMUNIZATION

ROSS, GIANNA JADE
Child's Name (Last name, First name)

07 | 07 | 2022
Birthdate

RICHTER, ALANA CHEYENNE
(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

07 | 01 | 2027
Date of Expiration
(Next required immunization or medical exemption due.)

[ ] (Fill in X)
Complete For K through 6th Grade
Child must be on 4 years and have met all requirements for school attendance.

[ ] (Fill in X)
Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade
AND must have Tdap and MCV4 administered

[ ] (Fill in X)
Complete For 11th Grade and higher
Fulfills requirements K through 10th grade
AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology*	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td	09 08 22	11 10 22	01 10 23	10 19 23			4				
Polio	09 08 22	11 10 22	01 10 23				3				
Hepatitis B	07 11 22	09 08 22	11 10 22	01 10 23			4				
Tdap							0				
MCV4							0				
HIB (Under Age 5)	09 08 22	11 10 22	10 19 23				3				
PCV (Under Age 5)	09 08 22	11 10 22	01 10 23	10 19 23			4				
Measles	07 13 23						1				
Mumps	07 13 23						1				
Rubella	07 13 23						1				
Hepatitis A (Born on/after 1/1/06)	07 13 23	05 07 24					2				
Varicella	07 13 23						1				
Recommended Vaccines (For Information Only)											
Rotavirus	09 08 22	11 10 22	01 10 23				3				
HPV							0				
Influenza							0				
Td (booster)							0				
Men-B							0				

Notes: Licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Turner Co Health Dept
745 Hudson Ave
PO Box 614
Ashburn, GA 31714

Certified by (Signature/Signature Stamp)

5 17 24
Date of Issue

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)

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

Child's Name (First, Middle, Last): Gianna Tolbert

Date of Birth: 7/7/2022 **Gender**: ☐ Male ☒ Female

Home Address: _____
Street City State Zip Code

Parent/Guardian Name (First, Middle, Last): _____

Parent/Guardian Contact Information:

Primary Phone#: _____ Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☐ **Distance visual acuity chart** (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ **Instrument-based/Photoscreener** (**Alternative method; see guidance below)

Results:
☐ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☐ **Pure tone audiometry** (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ **Automated Otoacoustic Emissions** (**Alternative method; see guidance below)

Results:
☐ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

DENTAL

Results:
☑ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☑ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

Dwayne Turner, DDS OCT 08 2026
Dwayne Turner, DDS

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

NUTRITION

Results:
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 in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

Vision and Hearing Screening Method Guidance:

* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☑ 5 Yr ☐

CHILD'S NAME: Gianna Tolbert | DATE OF BIRTH: 7-7-2022 | CENTER: KIDazzle

ABSOLUTE CARE PEDIATRICS

HEALTH CARE PROVIDER INFORMATION

PHYSICIAN ADMINISTERED BY (TYPE OR PRINT NAME): 5887 Mableton Pkwy Suite 230, Mableton, GA 30126 | SIGNATURE: Dr

CLINIC/TYPE OF PRACTICE: Sandy Springs, GA 30328 | TELEPHONE NUMBER: | DATE OF EXAM: 2/23/26

ADDRESS | VITIALS SIGNS: TEMP: 97.7 PLUSE: 98 SPO2: 98%

EXAMINATION RESULTS

HEIGHT: 38 inches | WEIGHT: 39 lbs/oz 2 | BLOOD PRESSURE: 92/53

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin	✓		Mouth/ Teeth/ Oral Health Assessment	✓		Genitalia		
Head	✓		Throat	✓		Neurologic	✓	
Neck	✓		Chest	✓		Extremities	✓	
Lymph Nodes	✓		Lungs	✓		Motor Ability	✓	
Eyes	✓		Heart	✓		Psychological	✓	
Ears	✓		Back	✓		Speech	✓	
Nose	✓		Abdomen	✓		Developmental	✓	
						Behavioral	✓	

Vision Acuity		Right	Left	Both
Date	10/23/26	20	20	20
Test Type	Passed	20	20	20

Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date	10/23/26	1000 Hz	✓ dB	✓ dB
Test Type	Passed	2000 Hz	✓ dB	✓ dB
		3000 Hz	✓ dB	✓ dB
		4000 Hz	✓ dB	✓ dB

Hemoglobin

☐ No Risk, screening not required (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ Risk factors NOT present: TB SKIN TEST NOT REQUIRED

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ

DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE

Lead Risk Assessment

☐ At Risk ☑ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Normal exam

Treatment/Restrictions/Recommendations for School

Continue with education

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL: ☐ Yes ☐ No (If yes, Medication Administration form needed)

Child is physically and emotionally able to participate in program: ☐ Yes ☐ No (If no, please explain in space above)

TYPE OF MEDICATION AND PURPOSE

HEALTH ASSESSMENT SCREENING

ABSOLUTE CARE PEDIATRICS

7/18 **Distribution:** White – Child's File Canary – Parent

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form: _____ **Staff Name:** Dr. Olivia Abbey DNP

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: Gianna Tolbert (first middle last)

Date of Birth: 07 / 07 / 2022 **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

10/23/26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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

10/23/26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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: 38 Weight: 39.2

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

10/23/26

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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:

DPH Form 3300 Rev. 2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Williams, Beaux J	**State Student ID:** 2640044
Date of Birth: 11/11/21	**Classroom:** Room 7
Parent / Guardian: Jacauria Smith Williams	**Contact Phone:** 404-664-9218

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (5 PENDING)
Remaining items needed for 100% compliance: **Child Certified Birth Certificate; Proof of GA Residency; Form 3231 (Immunization Certificate); Form 3300 (Screening Certificate); Parent Photo ID**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Williams_Beaux_J.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_68907d.pdf	6	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2640044
Student Name: Williams, Beaux J	**Date of Birth:** 11/11/21
Parent(s)/Guardian: Jacauria Smith Williams	**Phone:** 404-664-9218

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
[ACTION NEEDED]	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
[ACTION NEEDED]	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
[ACTION NEEDED]	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2640044

Scan the QR code or click the link above. Use child's Date of Birth (**11/11/21**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Williams, Beaux J** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Please write the school year in the box →

Pre-K Registration Form

2026-27 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME: KIDAZZLE-Summit	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: Williams			
CHILD'S FIRST NAME: BEAUX			
CHILD'S MIDDLE NAME: J	NAME SUFFIX:	(i.e. Jr, Sr, II,III)	
CHILD'S SOCIAL SECURITY#: 706594964	D.O.B. (MM/DD/BY): 2021-11-1	SEX: ☑ M	F
HOME ADDRESS (*Do not enter PO Box Info*): 222 Tuskegee st		COUNTY:	
CITY: Atlanta	STATE: GA	ZIP: 30315	HOME PHONE: (703)014454

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: Smith Williams	FIRST: Jacaura	MIDDLE INITIAL: S
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( ) 7703014454	
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. Tonya Smith	Grandmother	4046297957		
2. Savalia	Aunt	4043372687		

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.

Jacaura Smith Williams

Signature Parent/Guardian: *Jacaura Smith Williams* **DATE:** 2026-08-07

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. Tonya Smith		Grandmother	
2. Savalia Smith		Aunt	
3. MLakia Smith		Aunt	
4. Mona Hill		Grandmother	

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Cidjah Rodney Somersol,

DATE OF LAST FULL HEALTH SCREENING: 2026-08-03 PHONE: (4045160000

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

none

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

none

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:

NONE

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.

Jacaura Smith Williams

SIGNATURE (Parent/Guardian): Jacaura Smith Williams

DATE: 2026-08-07

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, BEAUX WILLIAMS, 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: Jacaura Smith Williams

SIGNATURE (Parent/Guardian): Jacaura Smith Williams

DATE: 2026-08-07

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-10 (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

BEAUX WILLIAMS

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:) West End of Atlanta
Program: After SchooProgram Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ _____ per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

☑**Breakfast** ☑**Lunch** ☑**Afternoon Snack** ☑**Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7 I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained inmy child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Jacaura Smith Williams

Parent/Guardian Signature: Jacaura Smith Williams

Date: 2026-08-07

Facility Administrator Signature: K. Harris

Date: 8/

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 2026-08-07		
CHILD INFORMATION:		
Legal First Name: BEAUX		Name Suffix (Jr,II,III):
Legal Middle Name: J		Name Child is Called:
Legal Last Name: WILLIAMS		
Child's Social Security # 706594964	DOB (M/D/Y): 2021-11-11	Gender: M F
Choose Not to Provide SSN	Date enrolled in Pre-K (M/D/Y): 2026-08-07	
PARENT/GUARDIAN INFORMATION:		
Last Name: Smith	First Name: Williams	
Relationship: Mother Father	Grandparent Guardian	Other
Email Address: jayesmith1000@gmail.com	Zip Code: 30315	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

Hispanic/Latino ☑ **Not Hispanic/Latino**

Decline to Answer

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

A language other than English

3.a. Which language is spoken in the child's home (other than English?

4. Was your child born as a:

☑ **Single Birth (1)**

Twin (2)

Triplet (3)

Quadruplet (4)

Quintuplet (5)

5. Does your child receive Special Education Services?

Yes ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

Individual Education Program (IEP) (Part B, Section 619, IDEA)

504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)

6. Does your child receive any of the following services?

Childcare and Parent Services (CAPS)

Child and Adult Care Food Program (CACFP)

Supplemental Security Income (SSI)

☑ **Supplemental Nutrition Assistance Program (SNAP)**

☑ **Medicaid**

Temporary Assistance for Needy Families (TANF)

Foster Care

7. Will the Pre-K center be providing transportation for your child?

Yes ☑ **No**

~~Jacaura Smith Williams~~

Jacaura Smith Williams

Parent/Guardian Signature

2026-08-07

Date

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Wilson, Rhamel Daylon	**State Student ID:** 2609513
Date of Birth: 08/29/22	**Classroom:** Room 7
Parent / Guardian: Dayashontay O. Wilson	**Contact Phone:** 404-740-9281

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (2 PENDING)
Remaining items needed for 100% compliance: **Child Physical SSN Card; Parent Photo ID**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Wilson_Rhamel_Daylon.pdf	1	✓ OFFICIAL
2	**Appendix D Roster Form**	Appendix_D_Rhamel_Wilson.pdf	1	✓ SIGNED
3	**Registration Application**	[Untitled]_f0a6c6.pdf	25	✓ ON FILE
4	**Form 3300 (Ear, Eye, Dental & Nutrition Screening)**	Rhamel_Wilson_Dental_3300.pdf	1	✓ VERIFIED
5	**Head Start Physical Exam (Form #78)**	Wilson, Rhamel Daylon - Head Start Physical Exam.pdf	1	✓ VERIFIED
6	**Form 3300 (Screening Certificate)**	Wilson, Rhamel Daylon - Form 3300 Screening Certificate.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609513
Student Name: Wilson, Rhamel Daylon	**Date of Birth:** 08/29/22
Parent(s)/Guardian: Dayashontay O. Wilson	**Phone:** 404-740-9281

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609513
Scan the QR code or click the link above. Use child's Date of Birth (**08/29/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Wilson, Rhamel Daylon** Parent Signature: _____ Date: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 08/03/2026

CHILD INFORMATION:

Legal First Name: Rhamel
Legal Middle Name: Daylon
Legal Last Name: Wilson
Name Suffix (Jr,II,III):
Name Child is Called:
Child's Social Security #: 714-73-0898
Date of Birth: 04/06/2022
Gender: M [X] F [ ]
Choose Not to Provide SSN [ ]
Date enrolled in Pre-K (M/D/Y): 08/03/2026

PARENT/GUARDIAN INFORMATION:

Last Name: Wilson
First Name: Dayashontay
Relationship: Mother [X] Father [ ] Grandparent [ ] Guardian [ ] Other [ ]
Email Address: dayashonlay.wilson@gmail.com
Zip Code: 30311

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

[ ] **Hispanic/Latino** [ ] **Not Hispanic/Latino**

[ ] **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

[ ] a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

[ ] b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

[ ] c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

[ ] d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

[ ] e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

[ ] f. **Decline to Answer**

3. What is your child's primary language?

[ ] **English**

[X] **A language other than English**

3.a. Which language is spoken in the child's home (other than English?

Briany Allen

4. Was your child born as a:

[X] **Single Birth (1)**

[ ] **Twin (2)**

[ ] **Triplet (3)**

[ ] **Quadruplet (4)**

[ ] **Quintuplet (5)**

5. Does your child receive Special Education Services?

[ ] **Yes** [ ] **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

[ ] **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

[ ] **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

[ ] **Childcare and Parent Services (CAPS)**

[ ] **Child and Adult Care Food Program (CACFP)**

[ ] **Supplemental Security Income (SSI)**

[ ] **Supplemental Nutrition Assistance Program (SNAP)**

[ ] **Medicaid**

[ ] **Temporary Assistance for Needy Families (TANF)**

[ ] **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

[ ] **Yes** [ ] **No**

Briany Allen

2026-07-31

Parent/Guardian Signature **Date**

Document Ref: 365905C3-37E0-4A54-B4C6-7FE5F48F07DA

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-2027 **School Year**

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDAZZLE-Summit

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME:	WILSON		
CHILD'S FIRST NAME:	RHAMEIZ		
CHILD'S MIDDLE NAME:	DAYLON	NAME SUFFIX:	(i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#:	711736898	D.O.B. (MM/DD/BY): 04062022	SEX: [X]M [ ]F
HOME ADDRESS (*Do not enter PO Box Info*):	57 Hardwick St SE	COUNTY:	Fulton
CITY: Atlanta	STATE: GA	ZIP: 30315	HOME PHONE: (404)4026816

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

PARENT/GUARDIAN INFORMATION			
Parent/Guardian #1 - LAST NAME: Wilson	FIRST: DAYASHONTAY	MIDDLE INITIAL: O	
Home Address (*If different from child*):			
City: Atlanta	State: GA	Zip: 30315	
Home Phone: (404)4026816	Cell Phone: (404)4026816		
Email Address: dayashontaywilson96@gmail.com			
Place of Employment: Paragon Systems	Work Phone: ( )		
Address: 684 Antone St			
City: Atlanta	State: GA	Zip: 30303	
Parent/Guardian #2 - LAST NAME: Dorsey	FIRST: Donny	MIDDLE INITIAL:	
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: ( )	Cell Phone: (678)7901822		
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.	Michelle Ampong	Godmom	4044095763		
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. Michelle Ampong	643 Mead St	Godmom	4044095763
2. Ruth Evans	1607 Meadow Crossing	Godmom	9044652387
3. Davonique Wilson	2607 Foxwood Pl Marietta	Auntie	4044878567
4. Tonzer Wilson	57 Hardwick St SE	Uncle	4707555089

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Greater Atlanta Pediatrics

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: 3.19.26

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, Rhaniel Wilson, 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: 3.19.26

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning _____ (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Rhamel Wilson
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ 90 **per week.**

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Lunch Afternoon Snack Dinner (school age only)

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: dyan

Date: 3.19.26

Facility Administrator Signature: K. Haus

Date: 8/3/26

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): 3/19/2026

CHILD INFORMATION:

Legal First Name: Rhamel
Name Suffix (Jr,II,III):
Legal Middle Name: Daylon
Name Child is Called: Mel
Legal Last Name: Wilson
Child's Social Security # ___-___-7147308 98
DOB (M/D/Y): 04/06/2022
Gender: M ☑ F ☐
Choose Not to Provide SSN ☐
Date enrolled in Pre-K (M/D/Y): __/__/__

PARENT/GUARDIAN INFORMATION:

Last Name: Wilson
First Name: DayaShontay
Relationship: Mother ☑ Father ☐ Grandparent ☐ Guardian ☐ Other ☐
Email Address: dayashontaywilson96@gmail.com
Zip Code: 30315

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☑ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☑ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☑ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☑ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☑ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☑ **No**

dyw
Parent/Guardian Signature

3.19.26
Date

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:

(i.) Provide information about the benefits of regular attendance.

(ii.) Support families to promote the child's regular attendance.

(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,

(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 3.19.26

Administrative Signature: _____ **Date:** 8/3/24

Teacher Signature: _____ **Date:** _____

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

VOID IF ALTERED OR ERASED

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH

Death Number	Local File Number	1. State File Number
		2022GA000032464

2.CHILD'S NAME FIRST 3.MIDDLE 4.LAST 5.JR.,III,ETC.	6.SEX (M or F)	7.DATE OF BIRTH (Mo., Day, Year)
RHAMEL DAYLON WILSON	MALE	04/06/2022

8.TIME OF BIRTH	9. THIS BIRTH (Single, Twin, Triplet, Etc.)	10.IF NOT SINGLE SPECIFY BIRTH ORDER
19:37 MILITARY	SINGLE	

11.CITY,TOWN, OR LOCATION OF BIRTH	12. HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
RIVERDALE	SOUTHERN REGIONAL MEDICAL CENTER

13. IF NOT HOSPITAL,Specify	14. COUNTY OF BIRTH
	CLAYTON

15. MOTHER'S NAME FIRST 16 MIDDLE 17.LAST	18.MAIDEN (Last Name)
DAYASHONTAY OMANIQUA WILSON	WILSON

19.DATE OF BIRTH (Month,Day,Year)	20.STATE OF BIRTH (If not U.S.A.,Name Country)	21.RESIDENCE - STATE	22. COUNTY
06/05/2002	NORTH CAROLINA	GEORGIA	FULTON

23. CITY,TOWN OR LOCATION	24.STREET AND NUMBER OF RESIDENCE
ATLANTA	1607 MEADOW CROSSING #D-4

25.MOTHER'S MAILING ADDRESS	26.RESIDENCE INSIDE CITY LIMITS? (yes or No)
1607 MEADOW CROSSING #D-4 ATLANTA GEORGIA 30344	YES

27.FATHER'S NAME FIRST 28.MIDDLE 29.LAST,JR., ETC.	30.DATE OF BIRTH (Month,Day,Year)	31.STATE OF BIRTH(If not U.S.A. ,Name Country)

32a. INFORMANT'S NAME (Type or Print)	32b. RELATION TO CHILD	33. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. (Yes or No)
DAYASHONTAY OMANIQUA WILSON	MOTHER	YES

34.I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35. DATE SIGNED (Mo ,Day,Year)	36. ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ BEVERLY JEAN MAULDIN	04/09/2022	(Name) RAMANA K PUPPALA 37.(Title) MD

38. CERTIFIER (Type or Print)	39. PHYSICIAN'S MEDICAL LIC. NO	40. CERTIFIER-MAILING ADDRESS (Street or R.F.D No., City or Town,State, Zip)
(Name) BEVERLY JEAN MAULDIN (Title) HOSPITAL STAFF		11 UPPER RIVERDALE ROAD SW RIVERDALE GEORGIA 30274

41. REGISTRAR (Signature)	42. DATE RECEIVED BY STATE REGISTRAR (Mo.,Day,Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	04/09/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE — Form 3901A (Rev. 01/2013)

Form 3972 (Rev.5/15)

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept [illegible] records clearly embossed. Chapter 31-10, Code of Georgia as amended.

1793336

State Registrar

County Registrar

STATE OFFICE GA VITAL RECORDS

C7047370

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

DEC 0 5 2022

STATE OF GEORGIA 1776

VOID IF ALTERED OR COPIED

Georgia Power

Customer Name
DAYASHONTAY O WILSON

Account Number
15435-89074

Please Pay By Jun 8, 2026

Total Due $ 312.19

Service Address
57 HARDWICK ST SE APT 3304

Service Period
Apr 15, 2026 - May 15, 2026

Web Access Code 421901

Account Number 15435-89074

Disconnect Notice

This bill includes past due charges of $137.87. To avoid your electric service being disconnected for non-payment, this amount must be received by June 10, 2026.

If service is disconnected, you must pay all outstanding bills and may be billed a reconnect charge and required to pay a deposit or additional deposit before service is restored. If you fail to pay your electric service bill each month by the due date, you may be required to pay a deposit or additional deposit even though service is not disconnected. You may contact us at 1-877-403-7149 for information on agencies that may be able to assist you in paying your past due bill, or assistance available if you have a serious illness in your household that could be aggravated by the disconnection of your electric service.

Esta es una notificación de desconexión de servicio. Para más información, llámenos al 1-800-253-1077.

Billing Summary

Previous Bill Amount		$ 354.63
Payment Received On 04/17/26	Thank You!	-216.76
Past Due Electric Service		$ 134.62
Past Due Late Payment Charge - Electric		$ 3.25
Current Electric Service		+172.30
Late Payment Charge - Electric		+2.02
	Total Due	**$ 312.19**

Balances unpaid after the due date are subject to a late charge of 1.5% of the amount due or $2.00, whichever is greater.

Manage Your Account

georgiapower.com or Mobile App
Pay bill | Start, stop, or transfer service
Enroll in paperless bill | Report an outage
View usage and money-saving tips

Enroll In Autopay

Pay your bill automatically from your bank account. Sign up at georgiapower.com/autopay.

Payment Options

georgiapower.com or Mobile App

Check/ACH **Debit Card**

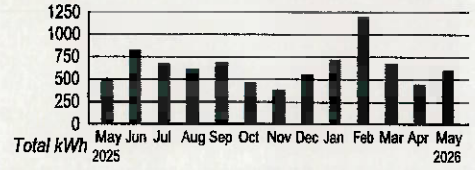
Additional Payment Options on back

For current billing details, turn page over

Usage Information

Total Used
597 kWh

Next Scheduled Read Date
On or after June 15, 2026



	1 Year Ago	Last Month	This Month
Total kWh Used	507	443	597
Average Daily kWh	17	16	20
Days In Billing Period	29	28	30
Billed Demand	5	6	7

15435-89074 11

PLEASE KEEP THIS PORTION FOR YOUR RECORDS.

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT, MAKING SURE THE RETURN ADDRESS SHOWS IN THE ENVELOPE WINDOW.

Account Number 15435-89074 **NC**

Disconnect Notice

Please Pay By Jun 8, 2026

Total Due $ 312.19

Georgia Power

BIN #10102
241 Ralph McGill Blvd.
Atlanta, GA 30308-3374

☐ Yes, I want to save a stamp on my next payment! Enroll me in paperless billing today. Please verify your email address on the back of this statement.

02154358907452000003121900000137870000000000000000001

DAYASHONTAY O WILSON
57 HARDWICK ST SE APT 3304
ATLANTA GA 30315

Mail To:
96 ANNEX
ATLANTA GA
30396-0001

Total Due Summary

Elec Service	172.30
Prev Service	134.62
Late Pymt Chg	2.02
Prev Late Pymt Chg	3.25
Total Due	**$ 312.19**

Haven at
South Atlanta

Residency Verification Letter
Haven at South Atlanta
Atlanta, GA 30315

xxx-xx-4786

Date: June 01,2026

To Whom It May Concern,

This letter serves as official verification Dayashontay Wilson is a current resident of **Haven at South Atlanta**, located in Atlanta, GA 30315. Ms Wilson resides in **Unit 3304** and has lived in our community since **June 30,2023**

The monthly rent that is charged for unit 3304 is in the amount of $1257

If you require any additional information or confirmation, please feel free to contact our management office.

Sincerely,

Toni Lingo
Property Manager
678-608-2139
ALingo@pennrose.com

Georgia Power

Customer Name	Account Number
DAYASHONTAY O WILSON	15435-89074

Please Pay By Jun 8, 2026

Total Due $ 312.19

Current Electric Service - Smart Usage

Next Scheduled Read Date: On or after June 15, 2026

Service Period	Meter #	Reading Type	Meter Reading Current	- Previous	x Constant	= Usage
Apr 15 - May 15	10791271	Tot kWh	3974	3377	1	597
		Pk kW 1 Hour	7.274		1	7.274
		Onpk kWh	0	0	1	0
		Offpk kWh	3974	3377	1	597

Billing Period
Apr 15, 2026 - May 15, 2026

Current Service	$ 138.71
Environmental Compliance Cost	14.79
Municipal Franchise Fee	4.73
Sales Tax	14.07
Total Current Electric Service	**$ 172.30**

Payment Options (cont.)

Customer Service
1-888-660-5890
7A-7P Mon-Fri

Power Outage Reporting
1-888-891-0938
24/7

Credit Card
Log in to georgiapower.com to pay or call BillMatrix directly at 1-800-672-2402.

Digital Wallet
Log in to georgiapower.com and link your Apple Pay, Google Pay, PayPal, or Venmo account to pay.

Cash or In Person
Use your account number to pay at thousands of **Authorized Payment Locations** (APLs). Text **GPPAY** to **99123** to locate an APL near you.

Mail
Georgia Power Payments
96 Annex
Atlanta, GA 30396
Holidays may impact payment posting

Visit **georgiapower.com/paymentoptions** for a complete menu of available options.

Consumer Check Conversion - When you pay your bill by check, you authorize us to make a one-time electronic debit from your banking account.

7993665904900063716825276589 60

By using this barcode to make a payment, you agree to the full terms and conditions available at www.georgiapower checkout.com. You may also visit the website to search payment locations and view your full e-receipts after making payments.

Do we have your correct primary phone number and email?

Why? When you call to report a power outage, our automated systems identify your address by your phone number. We may occasionally want to contact you via email with important information.

If your phone number or email address has changed, please update our records in the box below and mark the box on the front of the stub if you have entered a correction.

Primary Phone Number on file: **404-402-6816 at 57 HARDWICK ST SE APT 3304**

Rhanel

Email Address

CHILD HEALTH RECORD: FORM 1, GENERAL INFORMATION

CHILD'S NAME: Rhamel Wilson **SEX:** M **BIRTHDATE:** 4/6/2022

HEAD START CENTER: Kidazzle **PHONE:** _____

ADDRESS: _____

NAME OF INTERVIEWER: _____ **TITLE:** _____

1. PERSON INTERVIEWED DayaShanta Wilson
   DATE 3/9/24 RELATIONSHIP TO CHILD Mother
2. CHILD'S NICKNAME, IF ANY Mel
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   57 Hardwick St SE Atlanta GA 3304 Zip Code 30315
   PHONE 4042102651
4. FATHER'S NAME Donny Dessey
5. MOTHER'S NAME DayaShanta Wilson
6. GUARDIAN'S NAME DayaShanta Wilson
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   Mother
   PHONE _____, RELATIONSHIP _____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   ✓ English _____ Spanish
   _____ Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES (NO) EPSDT/Medicaid (Latest certification No.):
   YES (NO) Federal, State or Local Agency:
   YES (NO) In-Kind Provider:
   YES (NO) Other (3rd party):
   ID NO.:
   YES (NO) WIC
   YES (NO) Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    _____
11. DATE OF LAST VISIT TO DENTIST
    N/A
12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE *(Name, address, and phone no.):*
    Physician Greater Atlanta Pediatrics
    Clinic _____
    Hospital ER _____
    Other _____
    Dentist _____
13. IN CASE OF EMERGENCY NOTIFY
    (1) Michelle Ampong
    Relationship Godmom 4044095463
    Phone _____ or _____
    (2) Ruth Evans
    Relationship Godmom
    Phone 9044652337 or _____
    (3) Dayanique Wilson
    Relationship Auntie
    Phone 4044828567 or _____
14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites
    - ☐ Allergy, Medication
    - ☐ Other N/A

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER				
MOTHER DayaShanta Wilson	6502	✓		N/A
BROTHERS & SISTERS *(oldest first)*				
(1)				
(2)				
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

INTERVIEWER: GO T

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

CHILD HEALTH RECORD: FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:_____

CHILD'S NAME: Rhamel Wilson SEX: M BIRTHDATE: 4/16/2022

PERSON INTERVIEWED: DayaShantay Wilson DATE: 5/19/26 RELATIONSHIP: Mother

NAME OF INTERVIEWER:_____ TITLE:_____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?		✓	
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?		✓	
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?		✓	
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?		✓	
5. WHAT WAS CHILD'S BIRTH WEIGHT?			8 lbs., 1 oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?		✓	
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?		✓	
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?		✓	
9. IS MOTHER PREGNANT NOW?		✓	*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?		✓	
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?		✓	
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?		✓	

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ___SORE THROAT; ___COUGH; ___URINARY INFECTIONS OR TROUBLE URINATING, ___STOMACH PAIN, VOMITING, DIARRHEA?		✓	
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)*?	*	✓	
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?		✓	*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)*?	*	✓	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?		✓	
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*	✓	*If "yes" ask:* WHEN DID IT LAST HAPPEN?_____ WHAT MEDICINE?_____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*		✓	WHAT MEDICINE?_____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START?____HOW OFTEN?____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?	✓		(PHYSICIAN'S NAME:_____)
21. HAS CHILD HAD: ___BOILS, ___CHICKENPOX, ___ECZEMA, ___GERMAN MEASLES, ___MEASLES, ___MUMPS, ___SCARLET FEVER, ___WHOOPING COUGH?		✓	
22. HAS CHILD HAD: ___HIVES, ___POLIO?	*	✓	
23. HAS CHILD HAD: ___ASTHMA, ___BLEEDING TENDENCIES ___DIABETES, ___EPILEPSY, ___HEART/BLOOD VESSEL DISEASE, ___LIVER DISEASE, ___RHEUMATIC FEVER, ___SICKLE CELL DISEASE?	*	✓	*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)*? a WHEN EATING ANY FOODS?_____ b WHEN TAKING ANY MEDICATION?_____ c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?_____	*	✓	*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?		✓	DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?		✓	DESCRIBE: WHEN?

* *If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: _____ **DATE:** _____ **RELATIONSHIP:** _____

NAME OF INTERVIEWER: _____ **TITLE:** _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?
Water and speaking

28. DOES YOUR CHILD TAKE A NAP? ____NO, ✓ YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? ✓ NO, ____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? Verbally

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?
Normal interactions

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?
Well

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?
Well for the most part

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ✓ NO, ____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO ____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO ____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP	✓			
(b) CRAWL		✓	✓	
(c) WALK			✓	
(d) TALK	✓			
(e) FEED AND DRESS SELF		✓		
(f) LEARN TO USE THE TOILET		✓		
(g) RESPOND TO DIRECTIONS		✓		
(h) PLAY WITH TOYS	✓			
(i) USE CRAYONS	✓			
(j) UNDERSTAND WHAT IS SAID TO HIM/HER	✓			

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? ✓ NO, ____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? ✓ NO, ____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

YMCA OF METRO ATLANTA

EARLY LEARNING

CONSENT FOR EMERGENCY MEDICAL OR DENTAL TREATMENT

I, DayaShenta Wilson (Parent/Guardian), hereby give my consent for emergency medical or dental treatment services for my child Rhamel Wilson (Child's Name).

I consent for my child to be transported to and from the source of emergency treatment. I understand that this care may include examinations and any test which, in the opinion of the attending health care provider or dentist, deems necessary.

I agree that if my child incurs a deep laceration that may require sutures, or first aid services, I give my permission for this treatment to be provided by a qualified medical professional. **However, this does not give consent to perform surgical procedures without further informed consent from me.**

I have provided my child's school with emergency contact information (telephone numbers) that may be used to contact me or a designee in the event of a medical emergency.

First Year:	dyw **Parent Signature**	3/19/2026 **Date**	
First Year:	K. Harris **Staff Signature**	8/13/26 **Date**	
Second Year:	**Parent Signature**	**Date**	
Second Year:	**Staff Signature**	**Date**	
Third Year:	**Parent Signature**	**Date**	
Third Year:	**Staff Signature**	**Date**	

YMCA OF METRO ATLANTA

EARLY LEARNING

PERMISSION TO PERFORM SCREENINGS & EXAMINATIONS

I, Dayashema Rhamel Wilson, hereby give my consent for Rhamel Wilson
(Parent/Guardian) (Child's Name)

To receive the indicated screenings, assessments and examinations listed below. I understand that the YMCA of Metro Atlanta Early Learning, in accordance with the Performance Standard, deems these services a requirement and necessary. I also understand that the Early Learning Program may provide the services directly or by Certified Contract Providers designated by the program and that I will be informed of any abnormal results.

I understand that if I provide the YMCA of Metro Atlanta Early Learning Program with documentation of any of the applicable screening(s) or examinations listed below it may not be necessary to utilize this consent form for services.

I understand that by giving consent for a physical exam, I am giving the YMCA of Metro Atlanta Early Learning program permission to perform the exam with my child suitably draped, in accordance with the American Academy of Pediatrics (AAP).

I give the YMCA of Metro Atlanta Early Learning Program permission to perform *required* exams and/or screenings.

	Yes	No		Yes	No
Physical Exam	❑	❑	Hearing Screening	❑	❑
Blood Pressure Reading	❑	❑	Vision Screening	❑	❑
Hemoglobin	❑	❑	Developmental Screening	❑	❑
Lead Screening	❑	❑	Behavioral Screening	❑	❑
Height / Weight Measurements	❑	❑	Speech Screening	❑	❑

dyan — 8.19.26
Signature of Parent/Legal Guardian — Date

K. Hamo — 8/13/24
Family Services Assistant — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

DENTAL SERVICES IDENTIFICATION FORM

Child's Name: Rhamel Wilson **Parent/Legal Guardian:** DayaShonta Wilson

I understand that the YMCA of Metro Atlanta Early Learning Program requires a complete dental examination within (90) days of enrollment.

I also understand that if my child does not have a dental examination the Early Learning Program has contracted with licensed providers who may render these services to my child. I also agree to submit all required documentation (i.e. Medicaid card, Peach Care card, etc., if applicable) to the Family Services Assistant before my child's appointment.

I hereby give my permission to have Rhamel Wilson (Child's Name) examined by a licensed dentist contracted with the YMCA of Metro Atlanta Early Learning Program. I understand that the examinations may contain the following services:

Examination by a Licensed Dentist	X
Dental X-rays	X
Prophylaxis (teeth cleaned)	X

I further understand that I will be notified of the results of the dental examination and that I will be informed in writing if further follow-up treatment is required.

Parent/Legal Guardian Signature — Date: 8.19.24

Staff Signature — Date: 8/3/24

OR

I HEREBY DECLINE FOR MY CHILD TO BE EXAMINED BY AN AGENCY CONTRACTED DENTIST. I understand that it is a requirement of The YMCA of Early Learning to have a complete dental examination and, therefore, I will accept the responsibility for my child receiving a dental exam. I will ensure that the YMCA of Early Learning receives a copy of my child's current dental exam results.

Parent/Legal Guardian Signature — Date

Staff Signature — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization:
With the exception 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 parent.

I give Kidazzle (Name of Facility) permission to apply one or more of the following topical ointments/preparations to Mamai Wilson (Child's name) in KSem7 (Classroom) in accordance with the directions on the label of the container.

- DW Baby Wipes
- DW Band-aids
- DW Neosporin or similar ointment
- DW Bactine or similar first aid spray
- DW Sunscreen
- DW Insect Repellent
- DW Non-Prescription ointment (such as A & D, Desitin, Vaseline)
- DW Baby Powder

Other (please specify) _____

Parent/Guardian Signature — Date: 3.19.26

*Center should maintain in Daily Health Check notebook.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

AFFIDAVIT OF RELIGIOUS OBJECTION TO IMMUNIZATION

DayaShonay Wilson (name of parent or guardian) personally appeared before the undersigned notary public and swore or affirmed as follows:

1. I am the parent or legal guardian of Rhamel Wilson (name of minor child), born on 4/6/2022 (date of birth).
2. I understand that the Georgia Department of Public Health requires children to obtain vaccinations against the following diseases before being admitted to a child care facility or school: diphtheria; Haemophilus influenzae type B (not required on or after the fifth birthday); hepatitis A; hepatitis B; measles; meningitis; mumps; pertussis (whooping cough); pneumococcal disease (not required on or after the fifth birthday); poliomyelitis; rubella (German measles); tetanus; and varicella (chickenpox).
3. I understand that the Georgia Department of Public Health has determined:
   a. that the required vaccinations are necessary to prevent the spread of dangerous diseases among the children and people of this State;
   b. that the required vaccinations are safe;
   c. that a child who does not receive the required vaccinations is at risk of contracting those diseases; and
   d. that a child who does not receive the required vaccinations is at risk of spreading these diseases to me, to other children in the child care facility or school, and to other persons.
4. I sincerely affirm that vaccination is contrary to my religious beliefs, and that my objections to vaccination are not based solely on grounds of personal philosophy or inconvenience.
5. I understand that, notwithstanding my religious objections, my child may be excluded from child care facilities or schools during an epidemic or threatened epidemic of any disease preventable by a vaccination required by the Georgia Department of Public Health, and that my child may be required to receive a vaccination in the event that such a disease is in epidemic stages, as provided in Georgia Code Section 31-12-3 and DPH Rule 511-9-1-.03(2)(d).

This 19 day of March, 2026.

dwson
Parent or Legal Guardian

Sworn and subscribed before me
this 19th day of March, 2026.

Karen L. Harris
Notary Public
My commission expires 04/22/2029.

KAREN L HARRIS
Notary Public, Georgia
Fulton County
My Commission Expires
04/22/2029

Form 2208
Revised June 2019

YMCA OF METRO ATLANTA
EARLY LEARNING

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Rhamel Wilson	4/6/2022	57 Hardwick St SE
CHILD'S NAME	DATE OF BIRTH	ADDRESS

I, DayaShonayWilson, authorize the use or disclosure of the above-named individual's health information as described
(Parent/Guardian)
below.

1. The following individual or organization is authorized to make disclosure:
   Name/Organization: _____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   - Immunization record
   - Medication information
   - List of allergies
   - Most recent dental exam from _____
   - Most recent Health history and physical exam from_____
   - Nutrition Records (WIC, Assessments) from _____
   - Approval of returning to school
   - Specified lab results (Hemoglobin, Hematocrit, Lead or TB screening only)
   - Early Intervention record (Babies Can't Wait Program) _____
   - Disabilities records from _____
   - Medicaid, Peach Care or insurance eligibility _____
   - Other Specific Information must be written below_____

3. I understand that the information in my child's health record may include information related to my child's overall health status. It may also include information about behavioral or mental health services and other treatment.

4. The information may be disclosed to and used by the following individual or organization:

   Name: **YMCA of Metro Atlanta EARLY LEARNING** _____

   Address: _____Telephone _____ Fax: _ _____

   For the purpose of _____

5. I understand that I have a right to revoke the authorization at any time. I understand that if I revoke this authorization I must do in writing. I understand that the revocation may not apply to information I have already disclosed or released prior to this authorization.

6. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure emergency medical treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal Confidentiality Rules.

Signature of Parent or Legal Guardian: dyw Date: 3.19.26

Signature of Early Learning Staff: K. Hans Date: 8/3/24

WHITEFOOR

PEDIATRIC CONSENT FORM

understand that Whitefoord Inc. Health Centers and School Based Health Centers can provide comprehensive health services to my child. I also nderstand that I have the right to withdraw this consent at any time upon written notice to the medical director.

authorize (**check all services for which you consent**):

☑ Release of information from the child's medical record whenever necessary for payment, continued care or treatment, and ealthcare operations.

☑ I further give consent for staff to examine the child's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.

☐ For my child to receive medical care including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease anagement, referrals, and other minor office procedures.

☐ Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian

☑ For my child to receive dental care. This includes periodic dental examinations for my child, which may include screenings, hotographs, radiographs and any other acceptable methods for the dental evaluation and management of the child's dental health.

☑ For my child to receive behavioral health and counseling services, including one-on-one counseling, community resource referrals nd outreach and coordination of outside resources.

☑ Participation in health education sponsored/coordinated by Whitefoord Inc. (including, but not limited to: nutrition, sexual health, ealth and wellness, etc.

☑ That in the case of a medical emergency, I give permission to Whitefoord Health Centers to call emergency transport for my child.

n order for health center staff members to provide services, I authorize the school to release school records on a "need to know" basis to the Whitefoord Health and School Based Health Center staff members, and also for Whitefoord Health Center staff members to release medical ecords to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may nclude the following: immunization records, class schedules, parental contact, address, phone number, medical/behavioral health conditions, ealth screenings, medications, health care plans, or attendance information. The medical and mental health providers from Whitefoord Health enters may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed elow to release information to the Health Center staff members as needed. I hereby authorize the Health Center to provide the services as ndicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served egardless of the ability to pay. I hereby authorize Whitefoord Health Center staff members to release any medical records required by the nsurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, Health Center staff members will use nd share my Personal Health Information (PHI) for: treatment of my child's health condition, maintaining the continuity of my child's care and ayment for health services provided to my child, and routine health care operations including quality improvement, accreditation, educational urposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the ocation(s) my child receives his/her health care services.

have read and understand the above information and give permission for the child's care as described. I understand that I have the right to pt the child out of any medical testing or treatment. This consent will last for three years or the duration of the child's time at their current chool housing a Whitefoord School Based Health Center location.

Name of Parent or Legal Guardian (please print):	Name of Child (please print):
DayaSharta Wilson	Rhamel Wilson
Signature of Parent or Legal Guardian:	Relationship to Child: Date:
[signature]	Mother 3.19.26

Rev. Aug, 2021

PLEASE WRITE CLEARLY

WHITEFOORD

School Based Health Center Consent

School: _____
Grade: _____
Homeroom Teacher: _____

PATIENT INFORMATION

Name: Rhamel Wilson **Date of Birth:** 4/6/2022
Address: 57 Hardwick St SE Atlanta GA 30315
Home Phone: 4044026816 **Email address:** _____
Parent (please circle) (Mom) Dad Other: _____
Child lives with (please circle) (Mom) Dad Other: _____
Emergency Contact: Michele Amponsy
Phone: 4044095763 Cell Landline (please circle)
If unavailable, can Whitefoord discuss your child's personal health information with anyone else?
Name & Relationship to child: Unknown —
Phone Number: —

Insurance Information:

Insurance carrier name: _____
ID/Member Number: _____ Group Number: _____
Policy Holder & Date of Birth: _____

The following is required because we receive Federal funding for providing services at a discount. This information is for statistical purposes and will not be disclosed.

Total household income: 3600
Please circle: Hourly Weekly (Monthly) Yearly
Number of people in the household: 2
If there is no insurance coverage, would you be interested in discounts based on a sliding scale? Yes (No)
Would you like someone to contact you about applying for the discount? (Yes) No
Services requested (please circle): (Medical) (Dental) Counseling or Behavioral Health Services
Patient Gender Identity (please circle): (Male) Female
Patient Race (please circle): American Indian - Alaskan Native – Asian - Native American - (Black) - White
Ethnicity (please circle): Hispanic/Latino - (Not Hispanic/Latino) - Unknown

Patient Medical History:

Allergies: —
Please list any surgeries: —

Medical conditions:

Please circle answer
Asthma: Yes (No)
Diabetes Yes (No)
Other Yes (No) **Please explain if yes:** _____
Recent ER Visit (please circle): Yes (No)
If yes, please explain: _____
Reason for Visit: _____
Facility: _____
Current Medications: —
Please include doses, mgs, and how often taken
Do you have another Primary Care Provider? Yes (No)
Provider's Name: _____
Provider's Phone Number: _____

Parent Signature: dujuan **Date:** 3.19.26

Aug, 2021

SCHOOL-BASED HEALTH CENTER PATIENT CONSENT FORM

The Family Health Centers of Georgia, Inc.

School District **Date:** 3.19.26

[ ] Clayton [ ] Douglas [ ] Fulton: College Park or Lake Forest (circle one) [ ] Banneker

You must complete all information **USING INK, SIGN & DATE** in order for your child to receive healthcare services from the Health Center. It is your responsibility to notify us immediately of any changes in address, phone number or insurance.

PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name: DayaShantay (first) C (middle initial) Wilson (last)

Patient's Address: 57 Hardwick St SE (street)

City: Atlanta **State:** GA **Zip Code:** 30315

Patient's Social Security #: 714730898 **Date of Birth:** 4/6/2023 **Sex:** M

Birth Country: [✓] USA [ ] Other_____ **Primary Language:** [✓] English [ ] Other_____

School:_____

Grade:_____ Remedial/Special Education [ ] Yes [ ] No

Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Parent/Guardian's Email: dayashantaywilson0626@gmail.com

Emergency Contact Name: Michelle Ampong **Relationship to Patient:** Godmom

Emergency Contact #: 404 409 5763 Home #:_____ Cell #:_____

Work #:_____ Other #:_____

INSURANCE INFORMATION

[ ] No Insurance [ ] Medicaid #:_____ [ ] Private Insurance

Please indicate insurance company's name for private insurance:_____

Member's Name (as listed on insurance card):_____ Policy #:_____

Group #_____ Address:_____

Your child may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? [ ] Yes [ ] No

HEALTH INFORMATION

Medical Conditions (physical, behavioral health, dental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Allergies (medications, food, environmental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Dental Appointment in the past year: [ ] Yes [ ] No

PATIENT DEMOGRAPHICS

Special Populations (Check all that apply.)

[ ] Migrant Agricultural Worker/Farmer
[ ] Public Housing (live in or access to)
[ ] Seasonal Agricultural Worker/Farmer
[ ] Veteran
[ ] None of the above
[ ] Choose not to disclose

Housing (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] Public Housing (live in or access to)
[ ] Shelter
[ ] Street (car, outdoors, makeshift housing)
[ ] Transitional Housing
[ ] None of the above
[ ] Choose not to disclose

SELF REPORTED INCOME

Number of people living in household: _____ Household Income: _____ [ ] Choose not to Disclose

I hereby give consent for my child to continue to receive medical, behavioral and dental services (when available) from The Family Health Centers of Georgia's School-Based Health Center. I authorize any physicial-designated health professional, dentist or behavioral health provider working for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

DayeShanta Wilson
Name of Parent or Legal Guardian (please print)

Rhonnel Wilson
Name of Patient (please print)

X dyw
Signature of Parent or Legal Guardian

Mother
Relationship to Patient

Date: 3.19.26

School Parental/Guardian Consent and Release

STEP 1

Name of Child: Bhamel Wilson Child Age: 3

School Name: Successsouvneirs

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

In each step below, please read and check one box only. Once Steps 2-4 are completed, please sign at Step 5.

STEP 2: Dental Screening

YES ☑ NO ☐

Your Child is being offered a **FREE DENTAL SCREENING** as part of the Bright Smiles, Bright Futures (BSBF) program sponsored by Colgate-Palmolive Company ("Colgate"). By checking the "**YES**" box in Step 2, you are stating that you understand and agree that:

Colgate is providing the dental screening as a public service and your Child is participating in the BSBF dental screening voluntarily and at their and your own risk;

You are releasing and discharging Colgate and anyone affiliated with Colgate, including, without limitation, the volunteer dental professionals who are conducting the screenings, from any and all liabilities, suits, costs, or expenses in any way relating to the participation of the Child in the BSBF dental screening program; and

This Release is governed by New York law and that no changes to this Consent and Release are valid unless executed in writing by both you and Colgate.

STEP 3: Release of Protected Health Information

YES ☑ NO ☐

I understand that by checking "**Yes**" and signing this form, I authorize the dentist, dental specialist, or health care provider/entity conducting the BSBF program dental screening to use and disclose my child's protected health information, either in electronic or hardcopy form, to (i) another dentist, dental specialist, or health care provider/entity for treatment purposes, (ii) his or her school or employees of the school (such as teachers or medical staff) for informational, record keeping, or reporting purposes, or (iii) Colgate for informational, record keeping, or reporting purposes.

I understand that signing this authorization is voluntary. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that this authorization is valid until revoked. I understand I have the right to revoke this authorization at any time by sending written notification to Colgate-Palmolive Company, 300 Park Avenue, NY, NY 10022, Attn: Bright Smiles, Bright Futures. I understand that a revocation is not effective to the extent that any entity has already relied on this authorization to use or disclose my child's health information as described above.

STEP 4: Photo Release

YES ☐ NO ☐

Read and complete Step 4 regardless of whether your Child is participating in the BSBF dental screening program described in Step 2:

We may be taking photos and/or video of your Child at the BSBF program. By checking the "**YES**" box in Step 4, you are agreeing that:

Colgate and its BSBF partners, and anyone affiliated with Colgate or its BSBF partners (the "Colgate and BSBF Partners"), can use the photos and/or videos taken of your Child at the BSBF program in any and all media worldwide for as long as they wish to do so, including in external-facing media such as websites, social media, or brochures. The photos and/or videos taken of your Child will only be used to promote, publicize, or describe the BSBF program or Colgate's and/or its BSBF partners' community service or social responsibility efforts.

The Colgate and BSBF Partners can edit photos and/or videos taken of your Child without prior approval by you, and that Colgate is the owner of any and all photos and/or videos taken of your Child at the BSBF program; and

You are releasing and agreeing to hold harmless Colgate and its BSBF partners from any and all liability resulting from the use of any photos and/or videos taken of your Child at the BSBF event, and that this Consent and Release is governed by New York law.

STEP 5

Parent or Legal Guardian (Print name): DayaShanta' Wilson

Signature (of Parent or Legal Guardian): dyw

Date: 3.19.26

REMINDER! Please make sure you check either Yes or No in steps 2, 3 and 4.

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

Child's Name (First, Middle, Last): Rhamel D. Wilson

Date of Birth: 4/6/2022 **Gender**: ☒ Male ☐ Female

Home Address: _____
Street City State Zip Code

Parent/Guardian Name (First, Middle, Last): _____

Parent/Guardian Contact Information:

Primary Phone#: _____ Secondary Phone#: _____

VISION

☐ Uses corrective lenses
☐ Worn for testing
☐ Not worn for testing

Screening Method (Select one):
☐ **Distance visual acuity chart** (*Primary method); 20/50 age 3, 20/40 age 4 & 5, 20/32 age 6+
☐ **Instrument-based/Photoscreener** (**Alternative method; see guidance below)

Results:
☐ Passed both eyes
☐ Failed one or both eyes; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Optometrist
☐ Local Health Department
☐ "Prevent Blindness Georgia" Employee
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

HEARING

☐ Uses hearing aid / assistive device (do not screen)

Screening Method (Select one):
☐ **Pure tone audiometry** (*Primary method); 1000, 2000, and 4000 Hz at 20 dBHL
☐ **Automated Otoacoustic Emissions** (**Alternative method; see guidance below)

Results:
☐ Passed both ears
☐ Failed one or both ears; Needs further evaluation (explain in comments)
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Audiologist
☐ Local Health Department
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

DENTAL

Results:
☒ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☒ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

OCT 08 2026

Dwayne Turner, DDS
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

NUTRITION

Results:
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 in comments)
☐ Unable to complete screening (explain in comments)

Screened by:
☐ Physician
☐ Registered Dietician
☐ Local Health Department
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that the above screening was completed or attempted for this child.
Contact Information:

Vision and Hearing Screening Method Guidance:
* Primary method: Required when developmentally appropriate.
** Alternative method: Use only if primary method is not developmentally appropriate; document reason in comments.
For full guidance, including method selection, pass criteria, and contraindications, see Choosing the Right Screening Tool for Form 3300 at dph.georgia.gov/school-health.

Comments:

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☑ 5 Yr ☐

CHILD'S NAME: Rhamel Wilson | DATE OF BIRTH: 4-6-2022 | CENTER: K.I. Dazzle

ABSOLUTE CARE PEDIATRICS
9337 Kimridge Dr
Suite 230,
Sandy Springs, GA
30328

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME) | SIGNATURE: Dr. Olubunmi Ajayi

CLINIC/TYPE OF PRACTICE | TELEPHONE NUMBER | DATE OF EXAM: 10/23/26

ADDRESS

VITALS SIGNS: TEMP: 97.4 PLUSE: 74 SPO2: 98

EXAMINATION RESULTS

HEIGHT: 43 inches | WEIGHT: 43 lbs/oz 2 | BLOOD PRESSURE: 97/66

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin	✓		Mouth/ Teeth/ Oral Health Assessment	✓		Genitalia		
Head	✓		Throat	✓		Neurologic	✓	
Neck	✓		Chest	✓		Extremities	✓	
Lymph Nodes	✓		Lungs	✓		Motor Ability	✓	
Eyes	✓		Heart	✓		Psychological	✓	
Ears	✓		Back	✓		Speech	✓	
Nose	✓		Abdomen	✓		Developmental	✓	
						Behavioral	✓	

Vision Acuity		Right	Left	Both
Date	10/23/26	2y	2y	2y
Test Type	Passed	20	20	20

Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date	10/23/26	1000 Hz	✓ dB	✓ dB
Test Type	Passed	2000 Hz	✓ dB	✓ dB
		3000 Hz	✓ dB	✓ dB
		4000 Hz	✓ dB	✓ dB

Hemoglobin

☐ No Risk, screening not required (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	
		☑ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ Risk factors NOT present: TB SKIN TEST NOT REQUIRED

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ

DATE OF CHEST X-RAY | ☐ Normal | ☐ Abnormal | RX DATE

Lead Risk Assessment

☐ At Risk ☐ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Normal findings

Treatment/Restrictions/Recommendations for School

Continue education

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No (If yes, Medication Administration form needed)

Child is physically and emotionally able to participate in program ☐ Yes ☐ No (If no, please explain in space above)

TYPE OF MEDICATION AND PURPOSE

HEALTH ASSESSMENT SCREENING

ABSOLUTE CARE PEDIATRICS

7/18 **Distribution:** White – Child's File Canary – Parent

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form: _____ **Staff Name:** Dr. Olubunmi Ajayi DNP

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: Rhamel Wilson
first middle last

Date of Birth: 04 / 06 / 2022 **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

_____ 10/23/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-966-9596

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

_____ 10/23/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-966-9596

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: 43 Weight: 43

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

_____ 10/23/26
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS
[illegible] 678-966-9596

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:

DPH Form 3300 Rev. 2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Wright, Blossom Giilselle	**State Student ID:** 2609507
Date of Birth: 01/22/22	**Classroom:** Room 7
Parent / Guardian: Phaneissa (Phanesia) Shanaye Brown	**Contact Phone:** 404-376-8051

DECAL AUDIT COMPLIANCE STANDING: 100% COMPLETE • FULLY COMPLIANT
All Bright from the Start DECAL enrollment requirements, identity documents, and health certificates are on file.

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Wright_Blossom_Giilselle.pdf	1	✓ OFFICIAL
2	**Registration Application**	[Untitled]_26f262.pdf	18	✓ ON FILE
3	**Form 3300 (Certificate of Vision, Hearing, Dental & Nutrition Screening)**	CamScanner 10-13-2026 15.54.pdf	1	✓ VERIFIED
4	**Head Start Physical Exam (Form #78)**	Wright, Blossom Giilselle - Head Start Physical Exam.pdf	1	✓ VERIFIED
5	**Form 3300 (Screening Certificate)**	Wright, Blossom Giilselle - Form 3300 Screening Certificate.pdf	1	✓ VERIFIED

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:

1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 2609507
Student Name: Wright, Blossom Giilselle	**Date of Birth:** 01/22/22
Parent(s)/Guardian: Phaneissa (Phanesia) Shanaye Brown	**Phone:** 404-376-8051

Dear Parent/Guardian,
To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
✓ ON FILE	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
✓ ON FILE	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
✓ ON FILE	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
✓ RECEIVED	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**
Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=2609507
Scan the QR code or click the link above. Use child's Date of Birth (**01/22/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)
Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:
Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**
**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Wright, Blossom Giilselle** Parent Signature: _____ Date: _____

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2026-27 School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	KIDAZZLE-Summit

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)

CHILD'S LAST NAME:	Wright		
CHILD'S FIRST NAME:	Blessim		
CHILD'S MIDDLE NAME:	Glisell	NAME SUFFIX:	(i.e. Jr, Sr, II,III)
CHILD'S SOCIAL SECURITY#:	733-23-0910	D.O.B. (MM/DD/BY): 01/22/22	SEX: [ ]M [F]F
HOME ADDRESS (*Do not enter PO Box Info*):	2103 Irvin Court	COUNTY:	Cobb
CITY: Kennesaw	STATE: GA	ZIP: 30144	HOME PHONE: (678) 908-9612

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:	Brown	FIRST: Phaneissa	MIDDLE INITIAL: S
Home Address (*If different from child*):			
City:	State:	Zip:	
Home Phone: (678) 908-9612		Cell Phone: ( )	
Email Address:	phaneissab@gmail.com		
Place of Employment:	Internal Revenue Service	Work Phone: (678) 470-639-3303	
Address:	401 W. Peachtree Street		
City: Atlanta	State: GA	Zip: 30308-3510	

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.	Ijanai Wright	Aunt	404-547-2569		Ijanai.Wright3916@gmail.com
2.	Zaire Wright	Aunt	770-990-8620		Zaire.Wright2@gmail.com Zairehartman@gmail.com

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:** 1/27/2026

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.	Zjanai Wright	2103 Irvin Court, Kennesaw GA	Aunt	404.547.2569
2.	Laine Wright	505 Ruth Drive Holly Springs GA	Aunt	770.990.8620
3.				
4.				

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): Kaiser Permanente

DATE OF LAST FULL HEALTH SCREENING: 04/2025 PHONE: ( )

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

none

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

none

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:

none

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: 1/27/2026

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, Blossom Wright, 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: Kidazzle

SIGNATURE (Parent/Guardian): _____

DATE: 1/27/2026

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1.KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning _____ (date) and continuing until written notification is provided by either party. The operating hours are 6:30 am – 6:00 pm, Monday – Friday.

Blossom Wright
(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two week notice must be given for withdrawal. **I understand that no deduction will be made for holidays, inclement weather, or other times child is not in attendance at the center.** A vacation credit is given for each six months the child is enrolled.

I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only - I understand that there is no charge for tuition during the funded 6.5 hours of the instructional Pre-K day, 8:00 AM – 2:30 PM. A fee will be charged for Before and After Care for children in attendance outside the Pre-K hours.

(Tuition Fees:)
Program: _____ Program Pay: _____ Sponsor Pay:_____ Reg. Fee: $50.00
Total Weekly Tuition: _____

I understand that I am responsible for $ 50 per week.

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast **Lunch** **Afternoon Snack** **Dinner (school age only)**

5. **I understand that KIDazzle does not dispense medication. Special permission must be given for any medication to be kept on site or dispensed (Epi Pen, Asthma treatment, Skin medication).** If medication is kept on site I will provide a written authorization which includes: date, name of child; name of medication; prescription number; dosage; date and time of medication to be given. Medicine must be in the original container with child's name on it.

6. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily and must be taken to their assigned classroom and placed in teachers care.

7. I acknowledge that I have been given a copy of the Safe Sleep Policy and a signed copy will be retained in my child's file.

8. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

9. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc. which include my child. I authorize KIDazzle to obtain emergency medical care for my child if I am unavailable and the center deems necessary.

10. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

11. I grant permission for my child to be included in evaluations and pictures connected with the school program.

12. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

13. A copy of the Parent Handbook, which contains the Health and Discipline policies, is available on the KIDazzle website. I have been informed that if I cannot print a copy from the website a copy will be provided to me. I agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

14. I understand that KIDazzle will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is strongly encouraged in facility activities.

Parent/Guardian Signature: _____

Date: 1/27/2026

Facility Administrator Signature: _____

Date: 8/3/24

Georgia Dept of Early Care and Learning
RIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate.

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal First Name:		Name Suffix (Jr,II,III):
Legal Middle Name:		Name Child is Called:
Legal Last Name:		
Child's Social Security # ____-____-____	DOB (M/D/Y): ____/____/____	Gender: M ☐ F ☐
Choose Not to Provide SSN ☐	Date enrolled in Pre-K (M/D/Y): ____/____/____	
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	Other ☐
Email Address:	Zip Code:	

1. Identify your child's ethnicity, regardless of race, by selecting one of the below options.

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

☐ **Decline to Answer**

Select **ONE OR MORE** of the following races regardless of how you answered question one.

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment.

☐ f. **Decline to Answer**

3. What is your child's primary language?

☐ **English**

☐ **A language other than English**

3.a. Which language is spoken in the child's home (other than English? _____

4. Was your child born as a:

☐ **Single Birth (1)**

☐ **Twin (2)**

☐ **Triplet (3)**

☐ **Quadruplet (4)**

☐ **Quintuplet (5)**

5. Does your child receive Special Education Services?

☐ **Yes** ☐ **No**

5.a. If Yes, indicate which of the following Special Education Services your child receives.

☐ **Individual Education Program (IEP) (Part B, Section 619, IDEA)**

☐ **504 Plan/Individual Accommodation Plan (IAP) (Section 504 of the Rehabilitation Act of 1973)**

6. Does your child receive any of the following services?

☐ **Childcare and Parent Services (CAPS)**

☐ **Child and Adult Care Food Program (CACFP)**

☐ **Supplemental Security Income (SSI)**

☐ **Supplemental Nutrition Assistance Program (SNAP)**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

☐ **Foster Care**

7. Will the Pre-K center be providing transportation for your child?

☐ **Yes** ☐ **No**

_____

Parent/Guardian Signature **Date**

HEAD START ATTENDANCE POLICY

1302.16 Attendance.

a) Promoting regular attendance. A program must track attendance for each child.

1) A program must implement a process to ensure children are safe when they do not arrive at school. **If a child is unexpectedly absent and a parent has not contacted the program within one hour of program start time, the program must attempt to contact the parent to ensure the child's well- being.**

2) A program must implement strategies to promote attendance. At minimum, a program must:
(i.) Provide information about the benefits of regular attendance.
(ii.) Support families to promote the child's regular attendance.
(iii.) Conduct a home visit or make other direct contact with a child's parent if a child has multiple unexplained absences (such as two consecutive unexplained absences); and,
(iv.) Within the first 60 days of program operation, and on an ongoing basis, thereafter, use individual child attendance data to identify children with the patterns of absence that put them at risk of missing ten percent of program days per year and develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary.

3) If a child ceases to attend the program must make appropriate efforts to reengage the family to resume attendance, including as described in paragraph (a)(2) of this section. If the child's attendance does not resume, then the program must consider that slot vacant. This action is not considered expulsion as described in *1302.17.

Please follow our new process in promoting regular attendance and ensuring all children are in a safe place within one hour of start time.

- **Call or text 404-753-8884/404-884-1483**
  (Leave your name, child name and reason for absentee or lateness)
- **Email: karenharris@kidazzle.com**
  (Leave your name, child name and reason for absentee or lateness)

If the school has not heard from you by 9am, calls will be made, starting with you and contacts if needed. Then if we cannot get anyone on the phone a home visit will take place.

Parent(s) or Guardians Signature: _____ **Date:** 1/27/2026

Administrative Signature: K. Harris **Date:** 8/3/24

Teacher Signature: _____ **Date:** _____

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

STATE OF GEORGIA CERTIFICATE OF LIVE BIRTH	Death Number	Local File Number	1 State File Number 2022GA000007314

2 CHILD'S NAME FIRST 3 MIDDLE 4 LAST 5 JR ,III,ETC	6 SEX (M or F)	7 DATE OF BIRTH (Mo , Day, Year)
BLOSSOM GISELLE WRIGHT	FEMALE	01/22/2022

8 TIME OF BIRTH	9 THIS BIRTH (Single, Twin, Triplet, Etc)	10 IF NOT SINGLE SPECIFY BIRTH ORDER
06:22 PM	SINGLE	

11 CITY,TOWN, OR LOCATION OF BIRTH	12 HOSPITAL FACILITY NAME (If not Hospital,give street and Number.)
ATLANTA	NORTHSIDE HOSPITAL
13 IF NOT HOSPITAL,Specify	14 COUNTY OF BIRTH FULTON

15 MOTHER'S NAME FIRST 16 MIDDLE 17 LAST	18 MAIDEN (Last Name)
ALIYA MONIQUE WRIGHT	WRIGHT

19 DATE OF BIRTH (Month,Day,Year)	20 STATE OF BIRTH (If not U S A ,Name Country)	21 RESIDENCE - STATE	22 COUNTY
08/03/1999	COLORADO	GEORGIA	FULTON

23 CITY,TOWN OR LOCATION	24 STREET AND NUMBER OF RESIDENCE
ATLANTA	5675 ROSWELL RD APT 1B

25 MOTHER'S MAILING ADDRESS	26 RESIDENCE INSIDE CITY LIMITS? (yes or No)
5675 ROSWELL RD APT 1B ATLANTA GEORGIA 30342	YES

27 FATHER'S NAME FIRST 28 MIDDLE 29 LAST,JR., ETC	30 DATE OF BIRTH (Month,Day,Year)	31 STATE OF BIRTH(If not U S A ,Name Country)

32a INFORMANT'S NAME (Type or Print)	32b RELATION TO CHILD	33 PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER (Yes or No)
ALIYA M WRIGHT	MOTHER	YES

34 I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	35 DATE SIGNED (Mo ,Day,Year)	36 ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or Print)
Electronically signed by /S/ RONISA TUCKER	01/26/2022	(Name) KELLEY W STARNES 37 (Title) CNM/CM

38 CERTIFIER (Type or Print)	39 PHYSICIAN'S MEDICAL LIC NO	40 CERTIFIER-MAILING ADDRESS (Street or R F D No , City or Town,State, Zip)
(Name) RONISA TUCKER (Title) BIRTH RECORD CLERK		1000 JOHNSON FERRY ROAD ATLANTA GEORGIA 30342

41 REGISTRAR (Signature)	42 DATE RECEIVED BY STATE REGISTRAR (Mo ,Day,Year)
Electronically signed by /S/ CHRISTOPHER JP HARRISON	01/26/2022

GEORGIA DEPARTMENT OF PUBLIC HEALTH, VITAL RECORDS SERVICE **Form 3901A (Rev. 01/2013)**

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE GEORGIA DEPARTMENT OF PUBLIC HEALTH, STATE OFFICE OF VITAL RECORDS. THIS CERTIFIED COPY IS ISSUED UNDER THE PROVISIONS OF CHAPTER 31-10, CODE OF GEORGIA AND 511-1-3, DPH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept documents without the seal of the issuing agency. Records clearly embossed. Chapter 31-10, Code of Georgia as amended

6524107

State Registrar

County Registrar

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.

VOID IF ALTERED OR ERASED

Form 3972 (Rev.5/15)

IN THE PROBATE COURT OF COBB COUNTY
STATE OF GEORGIA

IN RE: ESTATE OF	)	
BLOSSOM WRIGHT	)	**ESTATE NO. 24-P-0759**
MINOR	)	

CERTIFICATE OF SERVICE

I certify that I have this date mailed (unless otherwise noted) in an envelope with the proper postage affixed thereto for first-class mail delivery a copy of **ORDER ESTABLISHING TEMPORARY GUARDIANSHIP OF MINOR ENTERED AUGUST 11, 2025** to the following parties:

PHANEISSA SHANAYE BROWN
2103 IRVIN COURT
KENNESAW, GA 30144

This 12th day of August, 2025

VANESSA ZUNIGA,Clerk of Probate Court
32 Waddell Street, Marietta, GA 30090

For questions email:
PROBATEGUARDIANSHIP@COBBCOUNTY.GOV

Temporary Letters of Guardianship may not be issued until the Temporary Guardian has had the oath administered. Please contact probatecourt@cobbcounty.gov to schedule your virtual oath, or you may take your oath in person in our office Monday through Friday, 8:00 AM to 5:00 PM. Once we receive the signed oath in our office, Letters may issue.

IN THE PROBATE COURT OF COBB COUNTY
STATE OF GEORGIA

IN RE: ESTATE OF	)	
BLOSSOM WRIGHT	)	**ESTATE NO. 24-P-0759**
MINOR	)	

ORDER ESTABLISHING TEMPORARY GUARDIANSHIP OF MINOR

Upon reading and considering the foregoing Petition (and Selection) and it appearing that each parent has acknowledged and consented to the Petition or been properly served with notice of this proceeding, and no objection having been filed,

IT IS ORDERED that **PHANEISSA SHANAYE BROWN**, Petitioner, be, and hereby is, appointed Temporary Guardian of the above Minor and that Temporary Letters of Guardianship issue to said Petitioner upon taking the oath as required by law.

KP IT IS FURTHER ORDERED that this guardianship shall be deemed to be a permanent guardianship for the purposes of the Guardian obtaining medical insurance coverage for the Minor because the Guardian has assumed in writing the obligation to support the Minor while the guardianship is in effect to the extent that no other sources of support are available.

SO ORDERED this 11th day of August, 2025

KRISTIN POLAND, Judge of the Probate Court

naf newamerican FUNDING

New American Funding, LLC
8201 N. FM 620, Suite 120
Austin, TX 78726
Address Service Requested

151987099
PHANEISSA BROWN
2103 IRVIN CT
KENNESAW, GA 30144

ANNUAL TAX AND INTEREST STATEMENT 1098-2025

Principal Balance

Current Payment	$2,618.82
Ending Balance	$329,200.09
Principal Applied	$1,079.33

Escrow Reconciliation

Beginning Balance	($562.06)
+ Deposits	$11,241.84
- Mortgage Ins Paid	$2,770.32
- Hazard Ins Paid	$2,224.53
- Taxes Paid	$5,481.92
Ending Balance	$203.01

PLEASE NOTE: The deductibility of the mortgage insurance premiums reported in box 5 should be reviewed with a tax professional to determine if it is eligible for tax reporting purposes.

☐ CORRECTED (if checked)

RECIPIENT'S/LENDER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.
New American Funding, LLC
8201 N. FM 620, Suite 120
Austin, TX 78726

800-893-5304

*Caution: The amount shown may not be fully deductible by you. Limits based on the loan amount and the cost and value of the secured property may apply. Also, you may only deduct interest to the extent it was incurred by you, actually paid by you, and not reimbursed by another person.

OMB No. 1545-1380
Form **1098**
(Rev. April 2025)
For calendar year 2025

Mortgage Interest Statement

RECIPIENT'S/LENDER'S TIN 91-0726495	PAYER'S/BORROWER'S TIN ***-**-**45
PAYER'S/BORROWER'S name PHANEISSA BROWN	
Street address (including apt. no.) 2103 IRVIN CT	
City or town, state or province, country, and ZIP or foreign postal code KENNESAW, GA 30144	
9 Number of properties securing the mortgage 1	10 Taxes Paid $5,481.92
Account number (see instructions) 1000409292 F.H.A.	

1 Mortgage interest received from payer(s)/borrower(s)
$2,412.17

2 Outstanding mortgage principal
$335,675.31

3 Mortgage origination date
3/24/2022

4 Refund of overpaid interest
$0.00

5 Mortgage insurance premiums
$2,770.32

6 Points paid on purchase of principal residence
$0.00

7 ☐ If address of property securing mortgage is the same as PAYER'S/BORROWER'S address, the box is checked, or the address or description is entered in box 8

8 Address or description of property securing mortgage
2103 IRVIN CT
KENNESAW GA 30144

Copy B
For Payer/ Borrower
The information in boxes 1 through 9 and 11 is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if the IRS determines that an underpayment of tax results because you overstated a deduction for this mortgage interest or for these points, reported in boxes 1 and 6, or because you didn't report the refund of interest (box 4), or because you claimed a nondeductible item.

11 Mortgage acquisition date

Form 1098 (Rev. 4-2025) (Keep for your records) www.irs.gov/Form1098 Department of the Treasury - Internal Revenue Service

Georgia Power

Customer Name	Account Number
PHANEISSA S MAYFIELD	51753-70014

Please Pay By Feb 9, 2026

Total Due $ 616.44

Service Address
2103 IRVIN CT

Service Period
Dec 16, 2025 - Jan 16, 2026

Web Access Code 120388

Account Number 51753-70014

Disconnect Notice

To avoid your electric service being disconnected for non-payment, this amount [illegible] by February [illegible] 2026

If service is disconnected, you must pay all outstanding bills and may be billed a reconnect charge and required to pay a deposit or additional deposit before service is restored. If you fail to pay your electric service bill each month by the due date, you may be required to pay a deposit or additional deposit even though service is not disconnected. You may contact us at 1-877-403-7149 for information on agencies that may be able to assist you in paying your past due bill, or assistance available if you have a serious illness in your household that could be aggravated by the disconnection of your electric service.

Esta es una notificación de desconexion de servicio. Para más información, llámenos al 1-800-253-1077.

Billing Summary

Previous Bill Amount		$ 640.04
Payment Received On 01/12/26	Thank You!	-344.00
Past Due Electric Service		$ 296.04
Current Electric Service		+320.40
	Total Due	**$ 616.44**

Balances unpaid after the due date are subject to a late charge of 1.5% of the amount due or $2.00, whichever is greater.

Manage Your Account

georgiapower.com or Mobile App
Pay bill | Start, stop, or transfer service
Enroll in paperless bill | Report an outage
View usage and money-saving tips

Enroll In Autopay

Pay your bill automatically from your bank account. Sign up at georgiapower.com/autopay.

Payment Options

georgiapower.com or Mobile App

Check/ACH Debit Card

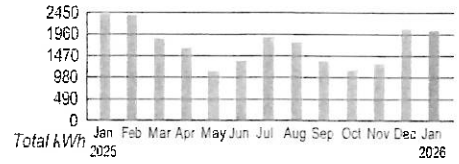
Additional Payment Options on back

For current billing details, turn page over

Usage Information

Total Used
2,054 kWh

Next Scheduled Read Date
On or after Feb 13, 2026



	1 Year Ago	Last Month	This Month
Total kWh Used	2,410	2,089	**2,054**
Average Daily kWh	78	65	**66**
Days In Billing Period	31	32	**31**
Billed Demand	10	9	**11**

51753-70014 12

PLEASE KEEP THIS PORTION FOR YOUR RECORDS

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT, MAKING SURE THE RETURN ADDRESS SHOWS IN THE ENVELOPE WINDOW

Account Number 51753-70014

Disconnect Notice

Please Pay By Feb 9, 2026

Total Due $ 616.44

Georgia Power

Bin # 10102
241 Ralph McGill Blvd
Atlanta, GA 30308-3374

☐ Yes, I want to save a stamp on my next payment! Enroll me in paperless billing today. Please verify your email address on the back of this statement.

02517537001436000006164400000296040000000000000000000

PHANEISSA S MAYFIELD
2103 IRVIN CT
KENNESAW GA 30144

Mail To:
96 ANNEX
ATLANTA GA
30396-0001

Total Due Summary

Elec Service	320.40
Prev Service	296.04
Total Due	~~$ 616.44~~

Keep this stub with your personal records. The other side contains important information.

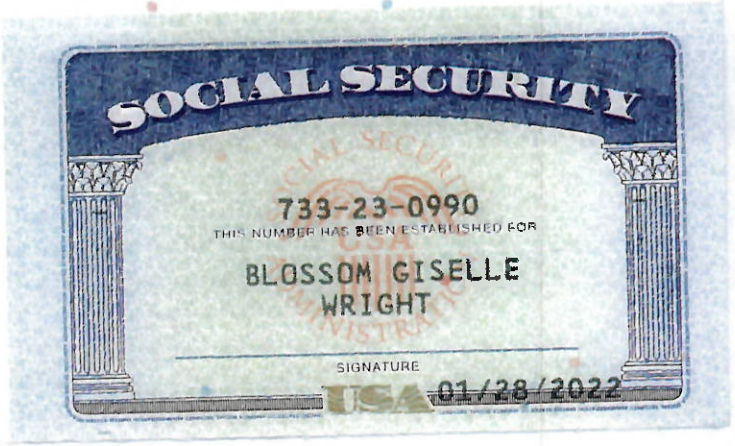
Please note: The date we issued this card is shown below the signature line.

BLOSSOM GISELLE WRIGHT
5675 ROSWELL RD APT 1B
ATLANTA GA 30342-1211

YOUR SOCIAL SECURITY CARD

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.



YMCA OF METRO ATLANTA

EARLY LEARNING

CONSENT FOR EMERGENCY MEDICAL OR DENTAL TREATMENT

I, Phanessa Brown (Parent/Guardian), hereby give my consent for emergency medical or dental treatment services for my child Blossom Wright (Child's Name).

I consent for my child to be transported to and from the source of emergency treatment. I understand that this care may include examinations and any test which, in the opinion of the attending health care provider or dentist, deems necessary.

I agree that if my child incurs a deep laceration that may require sutures, or first aid services, I give my permission for this treatment to be provided by a qualified medical professional. **However, this does not give consent to perform surgical procedures without further informed consent from me.**

I have provided my child's school with emergency contact information (telephone numbers) that may be used to contact me or a designee in the event of a medical emergency.

First Year:	**Parent Signature**	11/27/2026 **Date**
First Year:	**Staff Signature**	8/3/26 **Date**
Second Year:	**Parent Signature**	**Date**
Second Year:	**Staff Signature**	**Date**
Third Year:	**Parent Signature**	**Date**
Third Year:	**Staff Signature**	**Date**

YMCA OF METRO ATLANTA

EARLY LEARNING

PERMISSION TO PERFORM SCREENINGS & EXAMINATIONS

I, Phaniesa Brown, hereby give my consent for Blossom Wright

(Parent/Guardian) (Child's Name)

To receive the indicated screenings, assessments and examinations listed below. I understand that the YMCA of Metro Atlanta Early Learning, in accordance with the Performance Standard, deems these services a requirement and necessary. I also understand that the Early Learning Program may provide the services directly or by Certified Contract Providers designated by the program and that I will be informed of any abnormal results.

I understand that if I provide the YMCA of Metro Atlanta Early Learning Program with documentation of any of the applicable screening(s) or examinations listed below it may not be necessary to utilize this consent form for services.

I understand that by giving consent for a physical exam, I am giving the YMCA of Metro Atlanta Early Learning program permission to perform the exam with my child suitably draped, in accordance with the American Academy of Pediatrics (AAP).

I give the YMCA of Metro Atlanta Early Learning Program permission to perform *required* exams and/or screenings.

	Yes	No		Yes	No
Physical Exam	❑	❑	Hearing Screening	❑	❑
Blood Pressure Reading	❑	❑	Vision Screening	❑	❑
Hemoglobin	❑	❑	Developmental Screening	❑	❑
Lead Screening	❑	❑	Behavioral Screening	❑	❑
Height / Weight Measurements	❑	❑	Speech Screening	❑	❑

Signature of Parent/Legal Guardian — Date: 1/27/2026

Family Services Assistant — Date: 8/13/24

Revised June 2025

YMCA OF METRO ATLANTA

EARLY LEARNING

DENTAL SERVICES IDENTIFICATION FORM

Child's Name: Blossom Wright Parent/Legal Guardian: [signature]

I understand that the YMCA of Metro Atlanta Early Learning Program requires a complete dental examination within (90) days of enrollment.

I also understand that if my child does not have a dental examination the Early Learning Program has contracted with licensed providers who may render these services to my child. I also agree to submit all required documentation (i.e. Medicaid card, Peach Care card, etc., if applicable) to the Family Services Assistant before my child's appointment.

I hereby give my permission to have Blossom (Child's Name) examined by a licensed dentist contracted with the YMCA of Metro Atlanta Early Learning Program. I understand that the examinations may contain the following services:

Examination by a Licensed Dentist	X
Dental X-rays	X
Prophylaxis (teeth cleaned)	X

I further understand that I will be notified of the results of the dental examination and that I will be informed in writing if further follow-up treatment is required.

[signature]
Parent/Legal Guardian Signature — 1/27/2024 Date

K. Hall
Staff Signature — 8/3/24 Date

OR

I HEREBY DECLINE FOR MY CHILD TO BE EXAMINED BY AN AGENCY CONTRACTED DENTIST. I understand that it is a requirement of The YMCA of Early Learning to have a complete dental examination and, therefore, I will accept the responsibility for my child receiving a dental exam. I will ensure that the YMCA of Early Learning receives a copy of my child's current dental exam results.

Parent/Legal Guardian Signature — Date

Staff Signature — Date

YMCA OF METRO ATLANTA

EARLY LEARNING

Authorization to Dispense External Preparations
590-1-1-.20(1)

Parental Authorization:
With the exception 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 parent.

I give Kidazzle (Name of Facility), permission to apply one or more of the following topical ointments/preparations to Blossom Wright (Child's name) in KSEN (Classroom) in accordance with the directions on the label of the container.

- ✓ ____ Baby Wipes
- ✓ ____ Band-aids
- ✓ ____ Neosporin or similar ointment
- ✓ ____ Bactine or similar first aid spray
- ✓ ____ Sunscreen
- ✓ ____ Insect Repellent
- ✓ ____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
- ____ Baby Powder

Other (please specify) _____

_____ 1/27/2026

Parent/Guardian Signature — Date

*Center should maintain in Daily Health Check notebook.

YMCA OF METRO ATLANTA
EARLY LEARNING

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Blessin Wright	1/27/2026	2103 Irvin Court, Kennesaw GA
CHILD'S NAME	DATE OF BIRTH	ADDRESS

I, Pharessa Brun, authorize the use or disclosure of the above-named individual's health information as described
(Parent/Guardian)
below.

1. The following individual or organization is authorized to make disclosure:
   Name/Organization: _____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   - Immunization record
   - Medication information
   - List of allergies
   - Most recent dental exam from _____
   - Most recent Health history and physical exam from_____
   - Nutrition Records (WIC, Assessments) from _____
   - Approval of returning to school
   - Specified lab results (Hemoglobin, Hematocrit, Lead or TB screening only)
   - Early Intervention record (Babies Can't Wait Program) _____
   - Disabilities records from _____
   - Medicaid, Peach Care or insurance eligibility _____
   - Other Specific Information must be written below_____

3. I understand that the information in my child's health record may include information related to my child's overall health status. It may also include information about behavioral or mental health services and other treatment.

4. The information may be disclosed to and used by the following individual or organization:

   Name: **YMCA of Metro Atlanta EARLY LEARNING**

   Address: _____Telephone _____ Fax: _ _____

   For the purpose of _____

5. I understand that I have a right to revoke the authorization at any time. I understand that if I revoke this authorization I must do in writing. I understand that the revocation may not apply to information I have already disclosed or released prior to this authorization.

6. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure emergency medical treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal Confidentiality Rules.

Signature of Parent or Legal Guardian: _____ Date: 1/27/2026

Signature of Early Learning Staff: K. Haus Date: 8/3/24

Revised June 2025

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

Parent/Guardian Name: Phalissa (first) Shaney (middle) Brown (last)

Child's Name: Blossom Giselle Wright (first middle last)

Parent/Guardian Contact Information
Daytime phone number 678 [illegible]
Evening phone number
Cell phone number

Date of Birth: 1/22/2022 **Gender:** ☐ Male ☒ Female

Child's Home Address: 2103 Irvin Ct
Kennesaw GA 30144-5664

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

Ashlee Spence, LPN 2/17/2026
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
3640 TRAMORE POINT PKWY
AUSTELL GA 30106
Dept: 404-365-0966

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

Ashlee Spence, LPN 2/17/2026
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
3640 TRAMORE POINT PKWY
AUSTELL GA 30106
Dept: 404-365-0966

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

2/17/26
[illegible] Blossom Wright MD
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
3640 TRAMORE POINT PKWY
AUSTELL GA 30106
Dept: 404-365-0966

NUTRITION

☐ Unable to screen (explain why below)

Height 107 cm (42.13") Weight 18.8 kg (41 lb 8 oz)

BMI 16.44 BMI% 80%

☒ 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

Ashlee Spence, LPN 2/17/2026
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:
3640 TRAMORE POINT PKWY
AUSTELL GA 30106
Dept: 404-365-0966

FOR SCHOOL SYSTEM ONLY

	1st attempt	2nd attempt	Follow up for further evaluation Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on

Screeners' Comments:
Kaiser Permanente
West Cobb Medical Office
3640 Tramore Pointe Pkwy., SW
Austell, GA 30106-8825
(404) 365-0966

DPH Form 3300 Rev.2013

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME: Blossom Wright | DATE OF BIRTH: 1/22/2022 | CENTER: KIDazzle

ABSOLUTE CARE PEDIATRICS
5887 Mulligan Dr
Suite 230,
Sandy Springs, GA
30328

HEALTH CARE PROVIDER INFORMATION

PHYSICIAN ADMINISTERED BY (TYPE OR PRINT NAME) | SIGNATURE: Dr Abbey NP

CLINIC/TYPE OF PRACTICE | TELEPHONE NUMBER | DATE OF EXAM: 10/23/26

ADDRESS

VITALS SIGNS: TEMP: 98.2 PLUSE: 106 SPO2: 98

EXAMINATION RESULTS

HEIGHT: 46 inches 2 | WEIGHT: 46 lbs/oz 6 | BLOOD PRESSURE: 89/44

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin	✓		Mouth/ Teeth/ Oral Health Assessment	✓		Genitalia		
Head	✓		Throat	✓		Neurologic	✓	
Neck	✓		Chest	✓		Extremities	✓	
Lymph Nodes	✓		Lungs	✓		Motor Ability	✓	
Eyes	✓		Heart	✓		Psychological	✓	
Ears	✓		Back	✓		Speech	✓	
Nose	✓		Abdomen	✓		Developmental	✓	
						Behavioral	✓	

Vision Acuity		Right	Left	Both
Date	10/23/26	20/20	20/20	20/20
Test Type	Passed			

Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date	10/23/26	1000 Hz	dB	dB
Test Type	Passed	2000 Hz	dB	dB
		3000 Hz	dB	dB
		4000 Hz	dB	dB

Hemoglobin

☐ No Risk, screening not required (perform if at risk & complete below)

DATE | HGB(g/dl) | TREATMENT ☐ Anemia ☐ Iron Prescribed

Lead

DATE | LEAD LEVEL (mcg/dl) | ☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ Risk factors NOT present: TB SKIN TEST NOT REQUIRED

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN | RESULTS mm | ☐ Non Significant ☐ Significant | DATE READ

DATE OF CHEST X-RAY | ☐ Normal ☐ Abnormal | RX DATE

Lead Risk Assessment

☐ At Risk ☑ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Normal Exam

Treatment/Restrictions/Recommendations for School

Continue with education

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No (If yes, Medication Administration form needed)

Child is physically and emotionally able to participate in program ☐ Yes ☐ No (If no, please explain in space above)

TYPE OF MEDICATION AND PURPOSE

HEALTH ASSESSMENT SCREENING

ABSOLUTE CARE PEDIATRICS

7/18 **Distribution:** White – Child's File Canary – Parent

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form: _____ **Staff Name:** Dr. Olubola Abbey DNP

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: Blossom (first) Wright (middle) _____ (last)

Date of Birth: 01 / 22 / 2022 **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

10/23/24

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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

10/23/24

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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: 46.2 Weight: 46.6

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

10/23/24

Screener's Signature **Date**

I certify that this child has received the above screening.

Contact Information:

ABSOLUTE CARE PEDIATRICS

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:

DPH Form 3300 Rev. 2013

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL STUDENT COMPLIANCE FILE • MASTER DOCUMENT DOSSIER

Student Name: Jenkins, Aaliyah	**State Student ID:** 1789576852034
Date of Birth: 03/24/22	**Classroom:** Room 7
Parent / Guardian: Keisha Jenkins	**Contact Phone:** 404-555-8912

DECAL AUDIT COMPLIANCE STANDING: ACTION REQUIRED (4 PENDING)
Remaining items needed for 100% compliance: **Child Physical SSN Card; Form 3231 (Immunization Certificate); Form 3300 (Screening Certificate); Parent Photo ID**

INDEX OF ATTACHED DOCUMENTS IN THIS OFFICIAL DOSSIER:

#	DOCUMENT CLASSIFICATION	DOCUMENT TITLE / FILE NAME	PAGES	STATUS
1	**Parent Compliance Notice**	Notice_Jenkins_Aaliyah.pdf	1	✓ OFFICIAL
2	**Online Intake Application**	childcare_master_converted_Jenkins_1789577295857.pdf	8	✓ ON FILE

PRINTING & AUDIT FILING PROTOCOL FOR ADMINISTRATION:
1. This official dossier includes the certified cover summary followed immediately by verified scans and forms on file.
2. Keep this dossier inside the student's physical permanent compliance binder for Bright from the Start DECAL state audits.
3. Any updated parent submissions will be automatically appended to this digital dossier in real time.

File Verified & Certified by:
Karen Harris, Center Director

Signature: _____
KIDazzle Child Care & Learning Center

Date: _____
Audit Year: 2026–2027

KIDAZZLE CHILD CARE & LEARNING CENTER

PEACHTREE SUMMIT CAMPUS • GEORGIA LOTTERY PRE-K PROGRAM (SITE ID: 33915)

OFFICIAL NOTICE: OUTSTANDING ENROLLMENT & COMPLIANCE DOCUMENTATION

Audit Date: September 16, 2026	**Classroom:** Room 7 • **State ID:** 1789576852034
Student Name: Jenkins, Aaliyah	**Date of Birth:** 03/24/22
Parent(s)/Guardian: Keisha Jenkins	**Phone:** 404-555-8912

Dear Parent/Guardian,

To comply with mandatory **Bright from the Start: Georgia Department of Early Care and Learning (DECAL)** Operating Guidelines, all enrolled Pre-K children must have complete state compliance records on file within thirty (30) days of entry. Below is the updated compliance standing for your child as of **September 16, 2026**:

STATUS	REQUIRED DECAL COMPLIANCE ITEM	ACTION REQUIRED / STATE GUIDELINE
✓ ON FILE	**Completed Pre-K Registration Form**	Signed official enrollment application & consent agreements (Section 3.6).
✓ ON FILE	**Georgia Pre-K Roster Information Form (Appendix D)**	State demographic & household verification form signed by parent (Section 3.6).
✓ ON FILE	**Certified Birth Certificate**	Official birth certificate verifying child was age 4 on or before Sept 1 (Section 2.1).
[ACTION NEEDED]	**Child Social Security Card**	Signed SSN document or official state 30-day waiver form (Section 3.7).
✓ ON FILE	**Proof of Georgia Residency**	Current electric, gas, water bill, or valid residential lease agreement (Section 2.2).
[ACTION NEEDED]	**Parent / Guardian Photo ID**	Valid driver's license, state ID card, or passport copy.
[ACTION NEEDED]	**Form 3231 (Georgia Immunization Certificate)**	Valid, unexpired immunization record signed by physician (Section 3.13).
[ACTION NEEDED]	**Form 3300 (Screening Certificate)**	Ear, Eye, Dental, and Nutrition screening completed by doctor or clinic (Section 3.12).
✓ ON FILE	**CACFP Income Eligibility Statement (IES)**	Food program application verifying category eligibility (Section 2.5 / 3.9).

■ **FAST & SECURE: UPLOAD OUTSTANDING DOCUMENTS FROM YOUR PHONE**

Portal Web Link: https://kidazzle-webhook.bullmight.com/portal?child=1789576852034

Scan the QR code or click the link above. Use child's Date of Birth (**03/24/22**) as your access PIN to upload photos or PDFs directly from your camera in 60 seconds!

STATE COMPLIANCE DEADLINE: TUESDAY, SEPTEMBER 29, 2026 (5:00 PM EST)

Please upload online using the portal above, hand-deliver copies to the Front Desk, or email directly to:

Ms. Karen Harris (Center Director) • Email: **karenharris@kidazzle.com** • Phone: **(404) 753-8884**

**Note on Form 3300: If screening is pending a scheduled appointment, please provide doctor's appointment confirmation.*

PARENT ACKNOWLEDGEMENT & RECEIPT (Please sign and return to Front Desk):

Child: **Jenkins, Aaliyah** Parent Signature: _____ Date: _____

Enrollment Package

KIDazzle Child Care, Inc



Where Learning is Fun!!

*KID*azzle Child Care & Learning Center
Enrollment Application

Application Date: 09/16/2026 **Enrollment Date:** 2026-08-10 **Withdraw date:** _____

Sponsor's Name: Jenkins, Keisha
(Last) *(First)*

Address: 742 Evergreen Terrace NW
(Street)

Atlanta GA 30318
(City) *(State)* *(Zip Code)*

Home Phone: (404) 555-8912 ***Cell Phone:*** (404) 555-8912

Text to Cell Phone: Y X ***N*** _____ ***email address:*** keisha.jenkins@example.com

Place of Employment/Educational Program Grady Health System

Address of Employment/Educational Program 742 Evergreen Terrace NW, Atlanta GA 30318

Business Phone: (404) 555-8912 **Daytime Phone:** (404) 555-8912

Co-Sponsor's Name: _____
(Last) *(First)*

Address: _____
(Street)

_____
(City) *(State)* *(Zip Code)*

Home Phone: _____ ***Cell Phone:*** _____

Text to Cell Phone: Y ____ ***N*** ____ ***email address:*** _____

Place of Employment/Educational Program _____

Address of Employment/Educational Program _____

Business Phone: _____ **Daytime Phone:** _____

Child's Living Arrangements: ____Both X___Mother ____Father ___Other
Child's Legal Guardian(s): ____Both ____Mother ____Father ___Other

Child's Name: Jenkins, Aaliyah
(Last) (First) (MI)

Age: 4 **Birthdate:** 2022-03-24 **Sex** Male

Social Security Number (last 4 digits only) 5678

Has your child had previous child care experiences? X **Yes** ___ **No**

The child may be released to the person(s) signing this agreement or to the following: Under no circumstances will the child be released to anyone not on the this list without prior authorization from parent or guardian.

Name	Address	City	Relationship	Phone
Lisheba Brown	742 Evergreen Terrace NW, Atlanta, GA		Grandmother	(470) 927-7797

Persons to contact in the case of an emergency when parents cannot be reached: Please be sure to include someone that will be able to find you in an emergency.

Name	Address	City	Relationship	Phone
Lisheba Brown	742 Evergreen Terrace NW, Atlanta, GA		Grandmother	(470) 927-7797

Name of public or private school child attends, if any:
None (Infant / Pre-K Day Care)

Child's Medical Information:
Physician: Dr Chaudri **Clinic:** Dr Chaudri Pediatric Clinic
Address: Atlanta, GA
Telephone: (404) 873-1894

Does child have any physical problems, mental health disorders, mental retardation or developmental disabilities that would limit the child's participation in the center's programs and activities? ___Yes _X_No
If Yes, Please specify: _____

Does child have allergies? (Insects, medications, foods, etc.) ___Yes _X_No
If yes, please specify: _____

List any other special needs and or dietary restrictions that your child might have:
_____

Signed: Keisha Jenkins (Signed Digitally) **Date:** 09/16/2026

Office Use Only:
Group: _____ **Program:** _____
Program Payment: _____ **Sponsor Payment:** _____ **Class:** _____
Key: _____ **Code:** _____ **Enrollment Date:** _____

*KID*azzle Child Care & Learning Center

Parental Agreement Form

1. KIDazzle Child Care & Learning Center agrees to provide child care for the child listed below, beginning 2026-08-10 **(date) and continuing until written notification is provided by either party.** Aaliyah Jenkins

(Child's Name)

2. I agree to pay all tuition fees per week for as long as the child is enrolled in the program. A two (2) week notice must be given for withdrawal. I understand that no deduction will be made for holidays, vacations, or other times child is not in attendance at the center. I also understand that the center closes at 6:00 PM. I will be charged a late fee of $2.00 per minute, payable before my child returns the following day.

Pre-K Only **- I understand that there is no charge for tuition during the funded 6.5 hours of Pre-K but there will be a fee if my child participates in the before and/or after school care.**

(Tuition Fees:)
Program: Infant **Program Pay:** $0 **Sponsor Pay:**_____ **Reg. Fee: $50.00**
Total Weekly Tuition: $0

3. If a portion of the tuition is subsidized by another agency, I agree to provide all necessary paperwork and information in a timely manner.

4. I understand that KIDazzle does not dispense any medication with the exception of diaper creams and ointments.

5. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), persons authorized by parents, or facility personnel. Child must be checked in/out on the computer daily.

6. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, for example; telephone numbers, work locations, emergency contacts, child's physician, child's health status, and immunization records.

7. The facility agrees to keep me informed of any incidents including illnesses, injuries, adverse reactions to medicines, etc., which include my child.

8. KIDazzle Child Care & Learning Center agrees to obtain written authorization from me before my child participates in routine walking or transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

9. I grant permission for my child to be included in evaluations and pictures connected with the school program.

10. I will not bring my child to the center with signs/symptoms of illness (Fever, rashes, pink eye, diarrhea, etc...) and agree to pick up, or arrange for the child to be picked up immediately if he/she becomes sick at the center.

11. I have been given a copy of the Parent Handbook, which contains the Health and Discipline policies. I have received a copy and agree to abide by the policies and procedures for KIDazzle Child Care & Learning Center.

Signed: Keisha Jenkins (Signed Digitally) **Signed:** Robert Hill (Authorized Admin)

(Parent/Guardian) **(Facility Administrator)**

Date: 09/16/2026 **Date:** 09/16/2026

*KID*azzle Child Care & Learning Center

Emergency Medical Authorization

Should Aaliyah Jenkins**, _____ suffer an injury or illness while in the care of KIDazzle Child Care & Learning Center and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (we) shall assume responsibility for payment of services.**

I (we) agree to keep the facility informed of changes in telephone numbers, etc., where I can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of health care is:

Dr Chaudri _____ (404) 873-1894 _____

(Physician/Clinic) **(Telephone #)**

Known medical conditions (For example) diabetic, asthmatic, drug allergies):

None _____

_____

Signed: Keisha Jenkins (Signed Digitally) _____ **Date:** 09/16/2026 _____

Parent/Legal Guardian

Telephone: (404) 555-8912 _____

*KID*azzle Child Care & Learning Center

Infant Feeding Plan

Child's Name: Aaliyah Jenkins **Date:** 09/16/2026
Date of Birth: 2022-03-24

Does child take bottle? X Yes ____ No
Is the bottle warmed? X Yes ____ No
Does child hold own bottle? X Yes ____ No
Can the child feed self? ____ Yes X No

Does the child eat?

Strained foods ____ **Whole milk** X **Table Foods** X
Baby Foods ____ **Formula** X **Other** ____

What type of formula used? Whole Milk / Pureed Foods
Amount of formula to be given 6-8 oz per feeding
Updated amounts of formula: _____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Does the child take a pacifier? ____ Yes X No
When? N/A
Food likes Fruits, vegetables, oatmeal **Dislikes** None

Allergies - (which include any premixed formula)?
None

Child's Schedule

Breakfast 8:30 AM (Approximate Time) — Oatmeal, fruit, milk (Types and appropriate amounts of food)
Lunch 11:30 AM (Approximate Time) — Balanced warm lunch & milk (Types and appropriate amounts of food)
Dinner 3:30 PM (Approximate Time) — Afternoon snack & juice/water (Types and appropriate amounts of food)
Morning Nap 10:00 AM (Approximate Time) **Afternoon Nap** 1:30 PM (Approximate Time)

Instructions for the introduction of solid food
Age-appropriate soft table foods as approved by parent.

Any updated instructions regarding adding new foods or other dietary changes please list as needed None

Signed: Keisha Jenkins (Signed Digitally) **Date:** 09/16/2026
(Parent's Signature)

KIDazzle Child Care
External Preparations Authorization

I, Keisha Jenkins, give permission for the following checked items to be applied/used on my child.

[x] Latex Gloves
[x] Band Aids
[x] Medical Tape

[x] Baby Wipes
[x] Non prescription Diaper Ointment (Desitin, A&D etc.)
[x] Baby Powder
[x] Baby Lotion
[x] Aquafoor
[x] Vaseline

[x] Sunscreen
[x] Insect Repellent

[x] Antiseptic cleaning solutions (such as Betadine, alcohol, hyroden peroxide)
[x] Anti-Itch creme (such as hydorcortizone)
[x] Antibacterial ointment/spray (such as Bacitracin or Neosporin)
[x] Insect sting Preparation (over the counter, baking soda, meat tenderizer)

[ ] _____
[ ] _____

Aaliyah Jenkins
_____
Child's Name

Keisha Jenkins (Signed Digitally)
_____
Parent's Signature

09/16/2026
_____
Date

*Copy maintained in classroom and child's file

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply.** (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
Jenkins, Aaliyah	SNAP Case #409871234	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? (i.e., weekly, monthly, etc.) $_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. Keisha Jenkins (Categorical SNAP/TANF Eligible)	$ WAIVED	$ _____/_____	$ _____/_____	$ _____/_____
2. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II 3

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX 5678 ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of 6:30 AM [am/pm] to 6:00 PM [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday** **Monday** **Tuesday** **Wednesday** **Thursday** **Friday** **Saturday**

Circle the meals your child will normally receive while in care: **Breakfast** **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

PART IV: Signature
*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category**.*

Signature: X Keisha Jenkins (Signed Digitally) **Print Name:** Keisha Jenkins **Date:** 09/16/2026

Address: 742 Evergreen Terrace NW **City:** Atlanta, GA **State:** _____ **Zip:** 30318 **Phone:** (404) 555-8912

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: SNAP Waived **Per**: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size**: 3

Categorical Eligibility: check (✓) if applicable ☒ **Eligibility**: check (✓) one Free ☒ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: Robert Hill (Authorized Admin) **Date**: 09/16/2026

Confirming Official's Signature: _____ **Date**: _____

Follow Up Official's Signature: _____ **Date**: _____