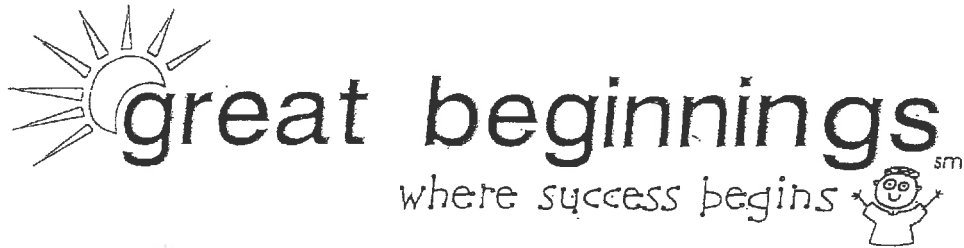


Summer Camp 2024

Welcome Packet

Please sign and return:

- ✓ **Vehicle Emergency Form** (All information must be completed)
- ✓ **Movie/ Moon Jump Permission Slip**
- ✓ **General Information Slip**
- ✓ **Activity Fee**



VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name _____ Date Of Birth _____

Address _____

City _____ State _____ Zip _____

Mother's Name _____

Home Phone _____ Work _____ Cell _____

Father's Name _____

Home Phone _____ Work _____ Cell _____

Person To Contact In An Emergency When Parents Cannot Be Reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical Facility The Center Uses: Gwinnett Physicians Group—North Gwinnett
4585 Nelson Brogdon Blvd., Sugar Hill, Phone 770-932-0547

Emergency Facility The Center Uses: Gwinnett Medical Center
1000 Medical Ctr. Blvd., Lawrenceville, Phone 678-442-4382

Child's Allergies _____

Current Prescribed Medication _____

Child's Special Needs And Conditions _____

In the event of an emergency involving my child, and if Great Beginnings cannot contact me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Parent Or Guardian's Signature _____

Witnessed By _____ Date _____

Tuition and Fees:

Tuition for the summer camp program will be \$165.00 per week per child with paid activity fee.

Full time students must pay for all nine weeks of summer. We will not offer any discounts for partial/absent weeks

Pay as you go weekly: \$185.00 per week.

Daily Drop In fee: \$65.00 per day.

field trip and activities, are an additional charge for Pay as you go/drop in students

This summer's activity fee is as follows:

Current Pre-K and Kindergarten students: \$210.00

Current 1st grade and older students: \$330.00

The 10% family discount will apply to **Full Time Campers** with a sibling in Pre-School. The 10% only applies to preschool tuition.

Activity fee must be paid in advance to reserve your child's spot in our summer camp program.

My child will participate in:

Full Time Weekly ()

Pay as you go weekly ()

Daily Drop In ()

Child's Name

Parent Signature & Date

Summer Safety

Reminders

Safety of our children is always our number one priority!

Here are a few reminders and important safety rules!

When picking up or dropping off your children, please be sure to use the drop and go method if using our drive-thru. If you plan on coming inside, please park in one of the spaces provided. You must sign your child in and out each day.

- * Only tennis shoes/sneakers should be worn. No sandals, flip-flops or opened toed shoes of any kind should be worn. Only on specified water days may children wear water type shoes. However, tennis shoes must still be worn to Great Beginnings.
- * Please be sure to speak with your child about good behavior both at school and on field trips; this includes bus safety!
- * At no time will bullying, disrespectful behavior to self or others, violence, foul language, etc. be tolerated. Great Beginnings reserves the right to dismiss children from any activity, field trip, or our summer camp program at any time without notice. **Fees are non-refundable!**
- * No chewing gum is allowed while children are at the center or on field trips.
- * Great Beginnings will not be responsible for any missing or stolen items that your child may bring with them; this includes video games, playing cards, money and/or toys of any kind.

Field trips are subject to change at the discretion of Great Beginnings Management. We will make every effort to reschedule any field trips that may be cancelled due to weather or unforeseen circumstances.

*There will be NO refunds on fieldtrips.

Child's Name _____ Parents Signature & Date _____

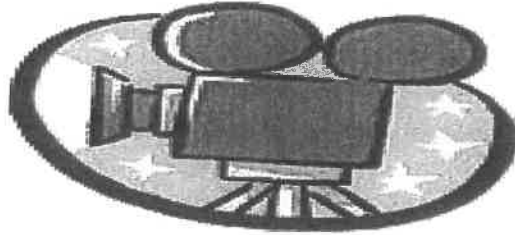
General Information

- * Great Beginnings will provide a morning snack, lunch, and afternoon snack for your child each day
- * Token money, which your child may wish to have on certain field trips, is not included. You may send additional money with your child if you so desire however, it is not required. Great Beginnings cannot be responsible for any lost, stolen or misplaced money or items, which your child may bring.
- * Your child will only go on trips which you authorize and are designated to their class and or age group. For example, if your child is in kindergarten and misses a trip they will not be allowed to make up the trip with another class.
- * All medication including sunscreen and bug spray, require a medication form. Medication forms can be found at the front desk.
- * You must sign your child in every morning and out every afternoon.

Child's Name

Parent's Signature & Date

MOVIES



We require signed permission slips for your child to watch PG rated movies.

Our PG movie collection consist of mostly Disney Movies such as

- * Moana
- * Toy Story
- * Turning Red
- * Coco
- * Etc.

_____ NO, I don't not give permission for my child to view PG rated movies.

_____ YES, I do give permission for my child to view PG rated movies.

Child's Name

Parent's Signature & Date

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Registration Form

(Please fill out ALL blanks and use a separate form for each child)

Great Beginnings offers a full-time program, which includes an education lesson plan, a variety of indoor and outdoor activities, morning and afternoon snacks, and a hot lunch. This program is offered Monday thru Friday from 6:30 A.M. to 6:30 P.M.

Registration Fee: \$ 100.00 for Single Child \$185.00 Multiple Children

Program	Price	Program	Price
6 Weeks to 12 Months	\$285.00 Per Week	Before School Only	\$65.00 Per Week
12 Months to 23 Months	\$275.00 Per Week	After School	\$95.00 Per Week
2 Years	\$255.00 Per Week	Before and After School	\$105.00 Per Week
3 Years	\$240.00 Per Week	School Holiday	\$30.00 Per Day
4 Years	\$230.00 Per Week	Early Release	\$20.00 Per Day
Summer Camp/Holiday Week	\$165.00 Per Week	Georgia Pre-K Meal	\$145.00 Per Month
Drop In with no registration	\$65.00 Per Day	AM / PM / DROP INS	\$20.00 / \$30.00

To reserve a space for your child, return this form along with your non-refundable registration fee. Tuition is due on Monday each week. If not paid before Tuesday at 6:00 P.M. a \$40.00 late fee is automatically added for that week. If tuition is not paid prior to Thursday each week, your child will not be allowed to attend. If your child is in the after school program and tuition is late, your child will not be picked up from school and alternate arrangements will need to be made.

For families with two or more children a 10% discount will apply to the child with the highest weekly tuition (Infant and Summer Camp rates excluded from family discount).

For school-age children we service the following schools:

Harmony	Buford City	Suwanee	Sugar Hill Christian
Patrick	Sycamore	Level Creek	Sugar Hill
Ivy Creek	White Oak	Riverside	Roberts
Lanier Middle	North Gwinnett Middle		

By signing this agreement I understand and acknowledge that WEEKLY TUITION IS DUE MONDAY OF EACH WEEK.

I also acknowledge that I have read, understand and agree with the centers Policies and Procedures.

The weekly tuition rate is \$ _____ for _____

Child's Name: _____
 First Middle Last

Date of Birth: _____ Age: _____ Sex Male Female

Elementary School Attending (if applicable) _____ Grade _____

Father Signature _____ Father Email _____ Date _____

Mother Signature _____ Mother Email _____ Date _____



Enrollment Form

(Please print and use a separate form for each child)

Enrollment Date: _____ Age: _____ SSN: _____

Child's Name: _____ Birthdate: _____ Sex: Male Female

Home Address: _____ City: _____ State: _____ Zip _____

Mother's Name		SSN	
Home Address	City	State	Zip
Home Phone	Cell Phone		
Place of Employment			
Work Address	City	State	Zip
Work Phone	Work Hours		

Father's Name		SSN	
Home Address	City	State	Zip
Home Phone	Cell Phone		
Place of Employment			
Work Address	City	State	Zip
Work Phone	Work Hours		

Child's Living Arrangements: Both Parents Mother Father Other _____
Child's Legal Guardian Both Parents Mother Father Other _____

This child may be released to the person(s) signing this agreement (or to the following):

Name:	Complete Address (Required)	Relationship	Phone #

Person(s) to contact by the case of an emergency when parents cannot be reached:

Name:	Complete Address (Required)	Relationship	Phone #

Child's Medical Information:

Child's Physician	Physician's address	City	State	Zip	Phone #
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Does your child have allergies (insects, medications, foods, etc.)? Yes No
 If yes, please specify: _____

Does your child have any physical problems, mental health disorders, mental retardation or developmental disabilities which would limit the child's participation in the Center's program and activities? Yes No
 If yes, please specify: _____

Are there any special procedures required in caring for your child? Yes No
 If yes, please specify: _____

Signed: _____ **Date:** _____ **Signed:** _____ **Date:** _____
Mother's Signature *Father's Signature*



EMERGENCY PARENTAL CONSENT

I, the parent or legal guardian of (child's name) _____ understand in the event my child is too ill to remain at Great Beginnings of Sugar Hill, the following procedure(s) will be observed:

If immediate care is not required, I will be contacted to make arrangements for my child's care. If Great Beginnings is unable to contact me, they may, at their discretion, contact the individual designated by me to contact in case of an emergency. I understand that if my child requires care and I cannot be reached, Great Beginnings would transport him or her to Gwinnett Medical Center. I understand that if my child requires emergency care and his or her safety will be jeopardized by underskilled transportation, then Gwinnett County 911 will be called for emergency medical services.

I have read, received and understand the center's emergency medical plan. I also understand that any expense incurred will be accepted by me.

Parents Signature

Additional Comments: (Food and/or Drug Allergies, Reactions, Medications): _____

No known food or drug allergies

Initial

Doctors Name: _____

Phone: _____

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VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name _____ Home Phone _____ Work _____ Cell _____

Father's Name _____ Home Phone _____ Work _____ Cell _____

Person to contact in an emergency when parents cannot be reach

Name: _____ Phone: _____

Child's Doctor _____ Phone: _____

Medical Facility The Center Uses: Gwinnett Physicians Group - North Gwinnett
4585 Nelson Brogdon Blvd., Sugar Hill, Phone: 770.932.0547
Emergency Facility The Center uses: Gwinnett Medical Center
1000 Medical Ctr. Blvd, Lawrenceville, Phone: 678.442.4382

Child's Allergies: _____

Current Prescribed Medication: _____

Child's Special Needs and Conditions: _____

In the event of an emergency involving my child, and if Great Beginnings cannot contact me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Parent or Guardian's Signature: _____

Witnessed by: _____ Date _____

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PARENTAL AGREEMENT WITH GREAT BEGINNINGS OF SUGAR HILL

1. Great Beginnings of Sugar Hill agrees to provide child care for: _____
(Child's name)

Monday through Friday, 6:30 AM to 6:30 PM, January through December, in accordance with the Policy and Procedures. The following meals will be served:

*Breakfast –Lunch –A.M. Snack –P.M. Snack

*There is an additional charge of \$2.00 per day for breakfast.

2. I agree to pay Great Beginnings for child care services according to their tuition guidelines.

3. Before any medication is dispensed to my child, I will provide a written authorization which includes: Date, Name of Child, Name of Medication, Prescription Number (if any), and Dosage. Medicine will be in the original container with my child's name on it.

Medication will only be given at 12:00 noon. When working with your physician please try to get medication that is given twice daily so it can be given at home.

4. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by Parent(s), or facility personnel. It will be the parent's responsibility to escort the child in and out of the building, and to sign the child in and out of the center each day. It is the parent's responsibility to take the child to the appropriate classroom before leaving each day.

5. I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they occur, (telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans, immunization records, etc.).

6. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

7. Great Beginnings of Sugar Hill agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

8. I have received a copy and agree to abide by the Policies and Procedures for Great Beginnings of Sugar Hill.

Signed: _____ Date: _____
Parent/Guardian

Signed: _____ Date: _____
Facility Administrator

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Please fill out to update your child's information.

Name of Child: _____ DOB: ____/____/____

_____ Initial here if NO allergies.

Food Allergy: Peanuts ___ Tree Nuts ___ Eggs ___ Gluten ___ Soy ___ Fish/Shellfish ___ Dyes ___

Tomatoes/Tomato Sauce ___ Strawberries ___ All Dairy ___ Milk Intolerant ___

Other _____ Suggestion for Milk Substitute: _____

Symptoms: _____

Other Allergy: Latex _____ Medication: _____

Seasonal ___ Dust ___ Cats ___

Other _____

Symptoms: _____

Parent/Guardian Signature: _____

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Authorization to Dispense External Preparations

Parental Authorization. Except 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 the day to be dispensed; and signature of parent.

I give Great Beginnings permission to apply one or more of the following topical ointments/preparations to my child _____ 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, Destin, Vaseline)

Baby Powder

Other (please specify) _____

Parent/Guardian Signature

Date