



Please write the school year in the box →

**Scholarship/Registration**  
 **School Year**

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

**SCHOOL SYSTEM/SCHOOL:**  
**LAST GRADE ATTENDED:**

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

CHILD'S LAST NAME: |||  
 CHILD'S FIRST NAME: |||  
 CHILD'S MIDDLE NAME: ||| NAME SUFFIX: ||| (i.e. Jr, Sr, II, III)  
 CHILD'S SOCIAL SECURITY#: D.O.B. (MM/DD/BY): SEX: [ ]M [ ]F  
 HOME ADDRESS (Do not enter PO Box Info): COUNTY:  
 CITY: STATE: GA ZIP: HOME PHONE: ( )

**If the Student/Parent receives SNAP, PEACH CARE, MEDICAID, MEDICARE please provide the following:**  
 CLIENT ID #: \_\_\_\_\_ PROGRAM: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**Parent/Guardian #1 - LAST NAME:** FIRST: MIDDLE INITIAL:  
 Home Address (If different from child):  
 City: State: Zip:  
 Home Phone: ( ) Cell Phone: ( )  
 Email Address:  
 Place of Employment: Work Phone: ( )  
 Address:  
 City: State: Zip:  
**PARENT SOCIAL SECURITY # D.O.B (MM/DD/BY)**

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

**EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)**

NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.				
2.				

I verify the above information to be correct, and I understand that completion of this form does not guarantee scholarship. If my child is allotted a scholarship, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without accurate information and documentation scholarship processing will be delayed or denied. I have attached a copy of accurate information and documentation to this registration form.

**Signature Parent/Guardian:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CHILD MAINTENANCE**

CHILD'S LIVING ARRANGEMENTS:  BOTH PARENTS  MOTHER  FATHER  OTHER

CHILD'S LEGAL GUARDIAN:  BOTH PARENTS  MOTHER  FATHER  OTHER

**THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:** NAME ADDRESS RELATIONSHIP CELL PHONE

1.

2.

3.

4.

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

DATE OF LAST FULL HEALTH SCREENING: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:** IEP OR 504 PLAN i.e special education services (ATTACH DOCUMENTATION)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:** ADHD, ADD, ATTACH DOCUMENTATION

\_\_\_\_\_

\_\_\_\_\_

**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 Scholarship providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Scholarship providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

**SIGNATURE (Parent/Guardian):** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PHOTOGRAPH/VIDEOTAPE RELEASE**

I hereby grant permission for the Scholarship providers specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Scholarship provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, \_\_\_\_\_, by photograph and/or videotape in connection with daily 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 Scholarship provider, DECAL, and other entities contracted by the Scholarship 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.

**PROVIDER NAME/ADDRESS :** UNFOLDING FAITH D.B.A CAMP EXPLOSION

**SIGNATURE (Parent/Guardian):** \_\_\_\_\_ **DATE:** \_\_\_\_\_