# Summer Camp 2023 Welcome Packet

# Please sign and return:

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

# great beginnings where success begins Vehicle Emergency Transportation Form

Child's Name		Date of Birth
Address		
		Zip Code
Mother's Name		
II .		Cell
Father's Name		
		Cell
Person to Contact in an Emergency V	When Parents Co	annot Be Reached:
Name		Phone
Child's Doctor		Phone
Medical Facility the Center Uses:	Gwinnett Phys	sicians Group-North Gwinnett Brogdon Blvd., Sugar Hill, GA
Emergency Facility the Center Uses:		althcare of Atlanta-Duluth Blvd., Duluth GA, 30096
Child's Allergies		
Child's Special Needs and Conditions		
In the event of an emergency involving hereby authorize any needed emerger all medical expenses incurred during t	ncy medical care	f Great Beginnings cannot contact me, I . I further agree to be fully responsible for my child.
Child's Name		

# **Tuition and Fees:**

<u>Tuition for the summer camp program will be \$150.00 per week per child with paid</u> 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: \$165.00 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: \$170.00

Current 1st grade and older students: \$270.00

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 is not responsible for any missing or stolen items that your child may bring with them. This includes video games, playing cards, money and our toys of any kind.

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

*There will be NO retunds on ti	eldtrips.	
Child's Name	Parents Signature & Date	

# **General Information**

- \* Great Beginnings will provide a morning snack, lunch, and afternoon snack for your child each day. Breakfast will be served daily from 7:00 am until 8:00 am and is an additional charge of 10.00 per week. No Breakfast will be served after 8:00 am.
- \* 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.
- \* Additional camp shirts are available for purchase. A \$ 10.00 charge will be added to your account for each additional shirt you acquire during the summer.
- \* 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.
  - \* I have Read and Agree to Great Beginnings Policies and Procedures

Child's Name

Parent's Signature & Date



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

Parent's Signature & Date

Child's Name

# Summer Camp 2023 Moon Jump and Water Slide Permission Slip!

Yes, my child has permissi activities at Great Beginnin	on to participate in the Moon Jump igs. (Please initial in box)
	e permission to participate in the eat Beginnings (Please initial in box)
	sion to participate in the water slide nings. (Please initial in box)
	ve permission to participate in the reat Beginnings (Please initial in box)
Child's Name	Parent Signature and Date



### Authorization to Dispense External Preperations

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.

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, De	stin, Vaseline)
Baby Powder	
Other (please specify)	
Darent/Cuardian St.	
Parent/Guardian Signature	Date

1191 Level Creek Road, Sugar Hill, GA 30518 770-945-3995 Fax 770-945-5500



# 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. Early morning breakfast (7:00 A.M.- 8:00 A.M.) is available at an additional charge of \$10.00 per week. There is a non-refundable registration fee of \$85.00.

Registration Fee: \$85.00 for Single Child \$150.00 Multiple Children

Program	Price	Program	Price
6 Weeks to 12 Months	\$260.00 Per Week	Before School Only	\$65.00 Per Week
12 Months to 23 Months	\$250.00 Per Week	After School	\$95.00 Per Week
2 Years	\$230.00 Per Week	Before and After School	\$105.00 Per Week
3 Years	\$220.00 Per Week	School Holiday	\$30.00 Per Day
4 Years	\$200.00 Per Week	Early Release	\$20.00 Per Day
Summer Camp/Ĥoliday Week	\$150.00 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. <u>Tuition is due on Monday each week.</u> If not paid before Tuesday at 6:00 P.M. a \$20.00 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). A 5% discount on total tuition is also given to parents who pay their tuition by the month, payment must be for four consecutive weeks. Please remember that some months have five weeks.

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		Nobelis

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:		*	ei		
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**

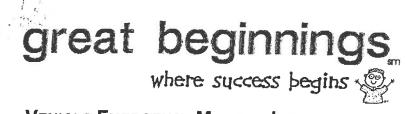
(Please print and use a separate form for each child)

			Age:	SSN	١:		
Child's Name:			Birthdate:		Sex:		Female
			_City:	S	tate:	_Zip	
	SSN		Father's Name			SSN	
City	State	Zip	Home Address		City	State	Zip
Cell Pho	ne		Home Phone		Cell Pho	one	
			Place of Employment				
City	State	Zip	Work Address		City	State	Zip
Work Hours			Work Phone		Work Hours		
case of an eme	rgency w	hen pa	rents cannot be reach				
	ess (riequiri		nalationship		Priorie #		
	cian's addr	ess	City	State	Zip	Phone :	
							#
es (insects, me		-	•	i □No			#
ysical problems	s, mental	health ter's pr	•	rdation o	r developmen Yes 🗖 No	ntal disabi	
ysical problems participation in ures required in	s, mental n the Cen n caring f	health ter's pr	disorders, mental reta ogram and activities?	rdation o		ntal disabi	
	City  City  Work Hours  S:  Both Pare  Both Pare  to the person(s  Complete Add  case of an eme  Complete Addr	SSN City State Cell Phone City State Work Hours State Work Hours City State Work Hours Complete Address (Require Case of an emergency we Complete Address (Require	SSN  City State Zip  Cell Phone  City State Zip  Work Hours  SS: Both Parents Mother Both Parents Mother to the person(s) signing this ag Complete Address (Required)  Case of an emergency when particle Address (Required)	SSN  City:  City:  Father's Name  Home Address  Home Phone  Place of Employment  Work Address  Work Phone  Ss: Both Parents Mother Both Parents Mother Both Parents Mother Father Other  to the person(s) signing this agreement (or to the following case of an emergency when parents cannot be reached Complete Address (Required)  Relationship	SSN City: S  City: S  SSN Cell Phone  City State Zip City State Zip  City State Zip  Work Hours  Ss: Both Parents Mother Father Other Both Parents Mother Father Other Complete Address (Required)  Case of an emergency when parents cannot be reached: Complete Address (Required)  Relationship	Birthdate: Sex: Mal   City: State:   State:	Birthdate: Sex: Male Femalon City: State: Zip  City: State: Zip  SSN  City State Zip  Cell Phone  City State Zip  Work Hours  State Zip  Work Phone  Work Address  City State  Work Phone  Work Hours  SSN  Father's Name  SSN  Home Address  City State  Work Address  City State  Work Phone  Work Hours  SSI  Both Parents Mother Father Other  Both Parents Mother Father Other  Complete Address (Required)  Relationship Phone #  Case of an emergency when parents cannot be reached:  Complete Address (Required)  Relationship Phone #



## EMERGENCY PARENTAL CONSENT

I, the parent or legal guardian of (child's name) understand in the event my child is too ill to remawill be observed:	ain at Great Beginnings of Sugar Hill, the following procedure(s)
case of an emergency. I understand that if my ch would transport him or her to Gwinnett Medical C and his or her safety will be jeopardized by under for emergency medical services.	ted to make arrangements for my child's care. If Great Begindiscretion, contact the individual designated by me to contact in ild reqires care and I cannot be reached, Great Beginnings senter. I understand that if my child requires emergency care reskilled transportations then Gwinnett County 911 will be called
I have read, received and understand the center's incurred will be accepted by me.	s emergency medical plan. I also understand that any expense
	Parents Signature
Additional Comments: (Food and/or Drug Allergies	s, Reactions, Medications):
No known food or drug allergies	Initial
Doctors Name:	Phone:





### VEHICLE EMERGENCY MEDICAL INFORMATION

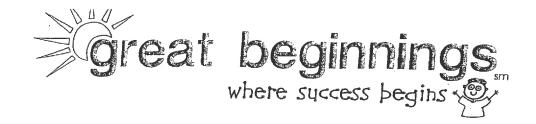
Child's Name: Date			ite of Birth:		
Address:		City:	State:	Zip:	
Mother's Name	Home Phone	Wo	ork	Cell	
Father's Name	Home Phone	Wo	ork	Cell	
Person to contact in an emergency when pare	ents cannot be reach				
Name:	Phone:				
Child's Doctor	Phone:				
Medical Facility The Center Uses:	Gwinnett Physicians Group - North Gwinnett				
Emergency Facility The Center uses:	4585 Nelson Brogdon Blvd., Sugar Hill, Phone: 770.932.0547 Gwinnett Medical Center 1000 Medical Ctr. Blvd, Lawrenceville, Phone: 678.442.4382				
Child's Allergies:	-	<del></del>			
Current Prescribed Medication:					
Child's Special Needs and Conditions:					
n the event of an emergency involving my child eeded emergency medical care. I further agre eatment of my child.	f, and if Great Beginnir e to be fully responsibl	ngs cannot cont e for all medica	act me, I hereby I expenses incur	authorize any red during the	
hild's Name					
arent or Guardian's Signature:					
itnessed by: Date					



## 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 P.M., 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:

Facility Administrator



Authorization to Dispense External Preperations

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.

to my-child	ne or more of the following topical ointments/preparations in accordance with the directions on the label
of the container.	an estions on the label
Baby Wipes	
Band-aids	
Neosporin or similar ointment	
Bactine or similar first aid spray	
Sunscreen	
Insect Repellent	
Non-Prescription ointment (such as A&D, De	estin, Vaseline)
Baby Powder	
Other (please specify)	
,	
Parent/Guardian Signature	Date



## Please fill out to update your child's information.

Name of Chile	j:
	Initial here if NO allergies.
Food Allergy:	Peanuts Tree Nuts Eggs Gluten Soy Fish/Shelifish Dyes
	Tomatoes/Tomato Sauce Strawberries All Dairy Milk Intolerant
	OtherSuggestion for Milk Substitute:
Symptoms:	
Other Allergy:	Later Medication:
	Seasonal Dust Cats
	Other
Parent/Guardian	Signature: