Angels Academy, LLC
5845 Campbellton Road
Atlanta, GA 30331

Angels Academy of Atlanta

Preschool
Pre-Kindergarten
Registration
Package

2025 – 2026 School Year

2025–2026 Student – Parent Registration Confirmation

Student Name:_____ _____

Parent Name:_____ _____

Classroom : _____

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Welcome to Angels Academy. We are pleased that your family has chosen our school for your child's early childhood care and education.

The following forms are enclosed in the 2025-2026 Student Registration package.

Enrollment Application and Other Forms:	**Received**
1) Student Enrollment Application – Personal Information	
2) Student Medical History – Emergency Treatment	
3) Parent-Provider Tuition Service Contract – 2025-2026	
4) Tuition Programs and Fee Schedule – 2025-2026	
5) Tuition Express Automatic Payment Application	
6) Parental Agreement with Child Care Facility	
7) Food Program – Income Eligibility Statement [IES]	
8) Request for School Meal Accommodation	
9) Physician's Prescription for Food Allergy (If Applicable)	
10) Photo/Video Release Policy	
11) Transportation Agreement-Preschool/Afterschool	
12) Angels Academy School Uniform Store	
13) 2025-2026 Parent and Student Handbook Receipt	

All information and forms must be completed, signed, and returned to the School Admissions Office along with the current school year registration, application, curriculum, materials, and uniform fees. **All Student Medical History questions and Emergency Treatment must be completed.** In addition to the enclosed registration forms, you will also receive the following student and parent school enrollment documents.

14) 2025-2026 Classroom Curriculum/Experience Plan _____
15) 2025-2026 Parent and Student Handbook _____

Upon receipt and acceptance of all properly completed forms and applicable school registration fees, your child will be officially enrolled at Angels Academy. Should you have any additional questions, please contact the school office at (404) 344-2444.

Parents: Please make sure that this form is signed, dated, and returned to Angels Academy with your children's registration package.

By signing this form, I/we confirm that we have received the above school enrollment information, forms, and policies. I/we acknowledge that all student school registration forms and releases will be retained as part of the student enrollment file.

_____ _____
Parent/Legal Guardian Signature **Date:**

_____
Printed Name:

_____ _____
Parent/Legal Guardian Signature **Date:**

_____
Printed Name:

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Student Enrollment Application

To enroll, please complete and sign this application. Submit this application, required enrollment forms, and payment for all registration fees and other school registration fees (see tuition plans and fees).

Student's Last Name **First Name** **Middle Name (Print name as it appears on Birth Certificate)** **Name to Use** >

Address where student resides **City** **State** **Zip Code**

Age Now **Date of Birth** **Student's Social Security #** **Gender** □ Male □ Female

Parent/Legal Guardian Comments: Include any family, custody or living arrangements related information

Parent/Legal Guardian Name

Home Address **City** **State** **Zip Code**

Parent/Legal Guardian Name

Home Address **City** **State** **Zip Code**

Home Phone	Father Mother Other	Cell Phone	Father Mother Other	Work Phone - Employer	Father Mother Other
	Father		Father		Father
	Father		Father		Father

Employment: Employer Name / Address Private/Public School Employment: Yes___No___ Confirm Employ ID	Father Mother Other	Employment: Employer Name / Address Private/Public School Employment: Yes___No___ Confirm Employ ID	Father Mother Other
Name:	Father	Name:	Father
Address:	Father	Address:	Father

Email Address – Personal Email / Other Contact Email	Father Mother Other	Email Address – Personal Email / Other Contact Email	Father Mother Other
	Father		Father
	Father		Father

Emergency Contact Information	Address	Contact Phone Number	Relationship
Name:			
Name:			
Name:			
Name:			

Person Responsible for Student:

As the person responsible for the student, I have read, understand, and agree to abide by all Angels Academy School Policies for the **2024 – 2025** school year.

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Parent/Legal Guardian Signature **Parent/Legal Guardian Signature**

Date _____

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Student Enrollment Application
Child's Personal Information

Has the student attended a private school, public school, preschool, or childcare center previously? **Yes** □ **No** □
If Yes, please provide private school, public school, preschool, or childcare center information below.

School/Center Name	Address	City/State/Zip	Dates Attended
School/Center Name	**Address**	**City/State/Zip**	**Dates Attended**

The primary reason(s) for transferring or withdrawing from the most recent school or childcare center.

Has the student previously been suspended or asked to withdraw from any school at any time? Yes □ No □

If Yes, please provide additional information:

Has the student been treated previously for ADD, ADHD, Dyslexia, or other personal medical condition including seizures that the school should be aware of? Has the student been prescribed medicine for any of these systems?

Yes □ No □ **If Yes**, please provide additional information:

Personal Independence:

Does the student independently feed himself or herself? Yes □ No □

Does the student have a positive and receptive attitude toward meal and snack time? Yes □ No □

What potty training stage is the student at this time? Not Potty Trained □ Partially Trained □ Fully Potty Trained

Other-P**lease Explain**:

Can the student manage his or her own clothing during potty time? Yes □ No □ Partially □

Does the student require any type of special assistance or observation during the school day? Yes □ No □

If Yes, please explain:

Emergency Family Medical Contact – Emergency Information:

Doctor, Practitioner, Clinic's Name	Address	City/State/Zip Code	Phone

Other Medical Contact Information - Name	Address	City/State/Zip Code	Phone

Student Enrollment Application

Personal Medical History

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Student's Last Name **First Name** **Middle Name** **Gender** □ Male □ Female

Student's Medical – Health History Checklist (Please Circle-Yes/No) – All Questions must be answered

Medical – Health	Yes	No	Additional Information –Detail–Explanation
Medical needs and special conditions: Include an explanation of any pre-existing medical conditions or allergies affecting your child that the school should be aware of. This would include illness, disease, and food allergies (*), reactions to medicine or shots, and general health concerns.	**Yes**	**No**	
If there any special medical treatment information and care instructions that the school should be aware of? If Yes, please explain. **Include "all" medications prescribed for long-term continuous use for pre-existing allergies (*), illness, or other health related issues.** **(*) Physician's Prescription for Food Allergy Form required for all confirmed Food Allergies and School Meal Accommodation requests.**	**Yes**	**No**	
Is your child currently under the primary care of a physician or other medical professional? If Yes, please explain.	**Yes**	**No**	
Has your child experienced a seizure or other physically related spells? If Yes, please explain.	**Yes**	**No**	
Does your child have any medical conditions related to excessive bleeding (free bleeder)? If Yes, please explain.	**Yes**	**No**	
Does your child experience nose bleeds? If Yes, please explain.	**Yes**	**No**	
Does your child have tubes in his or her ears?	**Yes**	**No**	
Does your child have any heart or other health issues that would prevent participation in indoor play or outdoor playground activities?	**Yes**	**No**	
Has your child been hospitalized within the last 12 months? If Yes, please provide details and include hospital name and location.	**Yes**	**No**	
Other health or medical related issues. Please explain (attach additional sheet if necessary)	**Yes**	**No**	

Parent/Legal Guardian Signature **Parent/Legal Guardian Signature** **Date**

Student Enrollment Application

Emergency Medical Treatment Consent Agreement

By signing the Emergency Medical Treatment Consent, I/We hereby give Angels Academy permission to provide first aid and obtain emergency medical care for my child_____. In case of emergency, we will attempt to contact the individuals listed in our records as responsible for the child. If the responsible parties cannot be

reached, we will leave a message at the number on file if possible and then we will attempt to contact one of the individuals listed as an emergency contact in the Student Enrollment Application. Anyone you list as an emergency contact must: 1) be authorized by you and have agreed to pick up your child in the event of an emergency or illness; and 2) should be able to communicate with preschool staff and respond to any situation. We will always contact emergency medical personnel first if the nature of the emergency warrants immediate medical care.

By signing the emergency medical treatment consent, I/We hereby authorize Angels Academy to arrange for transportation for my child to the emergency room of the hospital(s) listed below. I/We hereby grant consent for the hospital and its medical staff to provide my child with emergency medical treatment that an on-call hospital physician may deem necessary (including anesthesia). If you have not specified a specific hospital below, your child will be taken to and receive care at the nearest local area hospital. I/We agree to accept financial responsibility for all medical expenses incurred due to illness and/or medical treatment provided by an emergency medical provider.

Hospital:_____ **Nearest Hospital**: **Children's Healthcare of Atlanta**

Hospital/Emergency Clinic:_____

Emergency Family Medical Contact:

Doctor, Practitioner, or Clinic Name	**Address**	**City/State/Zip Code**	**Phone**

Emergency Medical Treatment Consent Confirmed By:

Parent/Legal Guardian Signature	**Date**	**Parent/Legal Guardian Signature**	**Date**

By signing the Student Enrollment Application, parents certify that they have provided all pertinent information on the Enrollment Application regarding medical conditions or allergies that may affect their child. Should any new medical conditions or allergies be discovered, it is the responsibility of the parent to notify the school.

Angels Academy is a Georgia school and childcare facility that is licensed to operate by Bright From The Start, Georgia Department of Early Care and Learning.

I/We verify that the included Student Enrollment and Medical information to be correct.

Parent/Legal Guardian Signature	**Date**	**Parent/Legal Guardian Signature**	**Date**
Parent's Full Name		**Parent's Full Name**	

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Tuition Programs and Fee Schedule –2025– 2026 School Year Term Fees

School Year Tuition Fee programs are based on a weekly advance fee payment rate. The full weekly tuition is due on Monday for the week of school attendance.

August 4, 2025 – May 22, 2026		Student	Full Day–School Year Programs		Full Day Plan [M-F]	2024-2025	School Year
Classroom		Registration	Age Group	Full School Term	Weekly Tuition Fee	Classroom	One-Time
Age Group	Classroom Name	Fee	6 Weeks – 60 Mos.	Tuition Fees	Payment Terms	Curriculum	Materials Fee
Infants	Snails	$150.00	6 Wks.– 12 Mos.	$10,780.00	$245.00	Snails	$20.00
Toddlers	Caterpillars	$150.00	12 Mos. – 24 Mos.	$10,560.00	$240.00	Caterpillars	$25.00
Twos	Crickets	$150.00	24 Mos. – 30 Mos.	$10,340.00	$235.00	Crickets	$45.00
Twos	Butterflies	$150.00	30 Mos. – 36 Mos.	$10,340.00	$235.00	Butterflies	$55.00
Threes	Fireflies	$150.00	36 Mos. – 42 Mos.	$10,120.00	$230.00	Fireflies	$85.00
Threes	Frogs	$150.00	42 Mos. – 48 Mos.	$10,120.00	$230.00	Frogs	$85.00
Fours – Pre-K	Bluebirds	$150.00	48 Mos. – 60 Mos.	$9,900.00	$225.00	Bluebirds	$125.00
GA Pre-K	Dragonflies	N/A	48 Mos.-60Mos.	N/A	N/A	Dragonflies	N/A

August 4, 2025 – May 22, 2026	Student	Tuition Programs – Age Groups Half-Day Programs**	Weekly Tuition Fee Plan [M-F]	**Half-Day Program	Subject to Classroom
Classroom	Registration Fee	36 months to 48 months - Threes 48 months to 60 months – Pre-K	6.5 Hours Daily Payment Terms	Threes / Pre-K Class Only	Space Availability
Threes – Fireflies/Frogs *Subject to Classroom Space Availability	$150.00	36 months to 48 months 8:00 am–2:30 pm–Part-Time–6.5 Hrs.	$180.00 Weekly $6,450.00 School Term $85.00 Materials Fee	*Late Pick-up Fees Apply	After 2:30 p.m.
Pre-Kindergarten – Bluebirds *Subject to Classroom Space Availability	$150.00	48 months to 60 months – Pre-K 8:00 am–2:30 pm–Part-Time–6.5 Hrs.	$180.00 Weekly $6,450.00 School Term $125.00 Materials Fee	*Late Pick-up Fees Apply	After 2:30 p.m.

August 5, 2023 – May 22, 2025	Student	School Age - After School Care School Break – Summer Session Program Tuition Programs – Age Groups	Weekly Tuition School Age – Full Day Plan Fee – [M-F]	Weekly Tuition School Age After Care Fee	After School Care [M-F] Daily Schedule
Classroom	Registration Fee				
School Age After School Care *Subject to Classroom Space Availability	$120.00	5 years to 12 years – Part-Time After School Care Only	NA	$80.00	3.5 Hrs. 3:00 pm – 5:30 pm
School Age–School Break [M-F] Summer Session – [M-F]	$50.00	5 years to 12 years – Full Day School Break & Summer Session Only	Full Week [M-F] $200.00 Each	NA	NA

*** All full and part-time tuition fee programs are contingent upon availability of classroom space. Additional tuition and late pick-up fees apply for student attendance time in excess of contract scheduled program weekly days or hours. Contact the school office for additional details.**

Weekly Tuition Fee – Payment Processing – Tuition Express

Tuition Fees listed are based on full school term advance weekly tuition fee payments paid by credit card, bank debit card through the student on-line Procare Portal account. In addition, Angels Academy offers the convenience of weekly automatic tuition payments processed through Tuition Express. The **Tuition Express Automatic Payment** processing system allows parents to pay their school tuition payments through pre-authorized recurring weekly, bi-weekly, or monthly automatic account debit of their bank checking account, bank debit card, VISA, Mastercard, or Discover credit cards. A safe, convenient, and on-time tuition and fee payment system. Please refer to the Angels Academy Parent-Student Handbook for additional Tuition Rate and Payment Terms and Policies.

Curriculum Materials Fee – School Uniform Fee – Activities/Events – Other Fee Information

Additional fees apply for classroom age group curriculum materials, school uniform shirts, and extracurricular activities and/or events. Multi-Student family plan tuition discounts are available for **eligible families**. Angels Academy accepts approved student and family tuition subsidy payments from participating federal, state, and local agencies. Contact the school office for additional details.

A late payment fee of $50.00 is added to all payments received after Tuesday of each week. **No tuition fee adjustments are made due to student absences, school weather or emergency closure, public or private school breaks, teacher in-service school training days, or scheduled holiday breaks including December Winter and Spring School Break.**

Please refer to the Parent-Student Handbook for additional school attendance and tuition fee details.

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Automated Payment Processing
Safe – Convenient - Easy

We are excited to offer the safety, convenience and ease of **Tuition Express™** – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AUTHORIZATION

I (we) hereby authorize **Angels Academy, LLC Atlanta, Georgia** (business name) to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give ten (10) days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name (as listed on account) **Phone #**

Address **City, State** **Zip**

Bank or Credit Union Name

Bank or Credit Union Address **City, State** **Zip**

□ **Checking** □ **Savings**

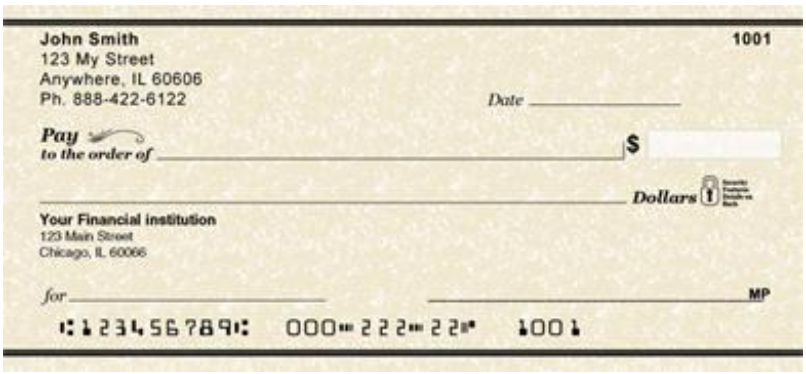
Routing Transit Number (see sample below) **Account Number (see sample below)**

Signature **Date**

For Official Use Only

Date Received **Employee Signature** **Date Confirmed**

[Bank Routing Number] **[**



Bank Account Number]

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Bright from the Start: Georgia Department of Early Care and Learning
Child Adult Care Food Program – Income Eligibility Statement

PART I: Child(ren) or Adult enrolled to receive day care				
Name: (Last, First and Middle Initial) **Date of Birth** **Age**	**Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.**	**Head Start Participant** ☐	**Foster Child** ☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A: A. Name (List everyone in household, including foster and non-foster children)	**B. Gross income and how often it is received** Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly				
	1. Earnings from work before deductions	**2. Welfare, child support, alimony**	**3. Social security, pensions, retirement**	**4. All other income**	**C. Check if No Income**
1.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
2.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
3.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
4.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
5.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
6.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐
7.	$ / Monthly	$ / Monthly	$ / Monthly	$ / Monthly	☐

PART III: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _____[am/pm] to _____[am/pm] on the following days.
☐ Check here if only before/after care is provided.

[Circle all that apply] Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care.

[Circle all that apply] Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).
An adult household member must sign this form. If Part II is completed, the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

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) listed on the form in Part I are enrolled for care.

Signature: X_____ **Print Name**_____ **Date**_____

Address:_____ **City**_____ **State: GA Zip**_____ **Phone**_____

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

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Official Use Only: 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 ☐ Month ☐ Year Household Size_____

Categorical Eligibility:_____ Date withdrawn_____ Eligibility: Free_____ Reduced_____ Paid_____ Tier I_____ Tier II_____

Temporary Free____ Reduced_____ Time Period:_____(expires after _____ days)

Determining Official's Signature:_____ Date:_____

Confirming Official's Signature:_____ Date:_____

Follow Up Official's Signature:_____ Date:_____

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Bright from the Start: Georgia Department of Early Care and Learning
Child Adult Care Food Program – Income Eligibility Statement

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: **T**he 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 Food Stamp, 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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the **USDA Program Discrimination Complaint Form**, (AD-3027) found online at: **http://www.ascr.usda.gov/complaint_filing_cust.html**, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: **program.intake@usda.gov.**

This institution is an equal opportunity provider.

Angels Academy
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Parent Request for School Meal Accommodation – Physician's Prescription for Food Allergy

Student:_____ **DOB**:_____ **Date**:_____

Dear Parent, Legal Guardian, and Physician:

A child with a confirmed food allergy, medical condition, or disability will be provided substitutions in foods when supported by a statement signed by a licensed physician. The following statement completed and signed by a physician must identify: the child's medical condition; an explanation of why the medical condition restricts the child's diet; the major life activity affected by the disability; and, the recommended food(s) that should be omitted and/or substituted from the child's diet. Food Restriction Accommodations will be initiated upon receipt of the physician's directions on this modified school meal accommodation form.

As the parent or legal guardian of the above-named student, I(we) do hereby request Angels Academy provide a modified school food program to accommodate the above-named student. I(we) **consent** to the release of all allergy medical information by and to my child's physician and Angels Academy for the purpose of providing my child with a school meal to accommodate his or her confirmed medical ***food allergy***.

_____ _____

Signature of Parent/Legal Guardian **Contact Phone Number**

Physician's Statement

Does the child have a confirmed medical disability or food allergy that restricts their diet?

*Medical Diagnosis:

_____

*Food Allergy:

_____

***Major life or physical activity affected by the student's medical disability or food allergy (please check all that apply):**

□ **Caring for one's self** □ **Eating** □ **Performing Manual Tasks** □ **Walking** □ **Sight/Seeing** □ **Hearing**

□ **Speaking** □ **Breathing** □ **Learning** □ **Working** □ **Other**

Length of Time School Meal/Dietary Restrictions: □ **Temporary until:** **Specify Date** □ **Life Long**

Food Allergy/Sensitivity: All students with a medically confirmed food allergy will require an Individual Health Accommodation Plan. When a confirmed food allergy results in a severe or possible health-threatening reaction, the child's condition would meet the definition of a "medical disability" and substitutions prescribed by the physician will be made for the student with the medical food allergy. Please note that "***Food Intolerance***" is not defined as a medical disability or food allergy.

Provide a list of all foods to be avoided. Parents, do not rely on lists of 'safe" pre-packaged foods since ingredients can change often and without warning, making such lists out-of-date quickly.

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Parent Request for School Meal Accommodation – Physician's Prescription for Food Allergy

Student Name: **Classroom:**

Physician, please indicate which foods should be "Excluded or Substituted" whenever possible. Pre-packaged foods may contain hidden ingredients unknown to the school or nutrition staff.

Food Product Food Group	Food Product Serving/Diet Modification	Suggested Substitution – Comments Additional Information
Eggs	□ Eggs are allowed in cooking □ Eggs are NOT allowed in cooking □ Avoid Egg (white, yolk, dried, powered, solids)	
Milk Milk Products Must have a signed medical statement from your child's physician Angels Academy Provides Whole and 1% Milk Only	□ Student may consume Fat Free Milk □ Student may consume Whole Milk only (Doctor Note) □ Student may consume Soy Milk only □ Student may consume Lactose Milk only □ Student may consume Lactaid Milk only □ Student may consume Rice Milk only □ Student may consume Almond Milk only □ Avoid Milk products: □ Cheese □ Yogurt □ Other □ Avoid Chocolate or Chocolate Milk	
Meat Chicken Pork Seafood	□ Avoid Meat Products □ Avoid Chicken Products □ Avoid Pork Products □ Avoid Seafood Products	
Nut Products Allergy	□ Avoid Peanuts – Allergic □ Avoid All Nuts – Allergic □ Student has EpiPen	
Gluten	□ Avoid Foods which contain Gluten □ Wheat □ Rye □ Oats □ Barley □ Other	
Other Food Groups	□ Avoid Tomatoes □ Avoid Strawberries □ Avoid Potatoes–Type □ Avoid Pasta–Type □ Other Foods to Avoid	
Other Medical Food Allergies		

Physician's Name:

Medical Facility:

Address **City/State/Zip** **Phone Number**

Physician's Signature **Date**

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Medical Condition – Food Allergy Action Plan
Student: **D.O.B:** **Classroom:**
Medical Condition – Food Allergy To:

Asthmatic: ☐ Yes ☐ No **Attach Additional Medical Treatment Instructions if required**

Step One – Recommended Treatment Procedure

Give Recommended Medication or Other Treatment **(To be determined by physician authorizing treatment)**

Symptoms	Description	Medication	Medication	Other
No Symptoms	If a food allergen has been ingested, but no symptoms	□ Epinephrine	□ Antihistamine	
Mouth	Itching, tingling, or swelling of the lips, tongue, mouth	□ Epinephrine	□ Antihistamine	
Skin	Hives, itchy rash, swelling of the face/extremities	□ Epinephrine	□ Antihistamine	
Stomach	Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□ Antihistamine	
Throat	Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine	
Lung	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine	
Heart	Thready pulse, low blood pressure, fainting, pale	□ Epinephrine	□ Antihistamine	
Other	If reaction is progressing (several areas) give:	□ Epinephrine	□ Antihistamine	
Other		□ Epinephrine	□ Antihistamine	

Suggested Dosage:

Epinephrine (EpiPen): Inject intramuscularly (circle one): EpiPen® - EpiPen®Jr - Twinject™0.3 mg - Twinject™0.15 mg
(see page 2 for instructions)

Antihistamine: Give: _____
Medication Type / Dosage / Route

Other Medication: Give: _____
Medication Type / Dosage / Route

Step Two – Emergency Calls – Contact Numbers

1. Call 911 – State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr. **Contact at:**

3. Emergency Contacts:

a) **Phone:** **b)** _____

_____**Phone:**_____ **Even if the Parent/Guardian/Emergency Contacts cannot be reached, as per Action Plan medical instructions, medicate the child and contact EMS or take the child to the closest Medical Facility.** _____

_____ _____

Parent/Guardian Signature **Date** **Physician's Signature (required)** **Date**

Medical Condition – Food Allergy Action Plan
Student Name: _____ **Classroom:** _____

Trained Staff Members	Classroom / Position

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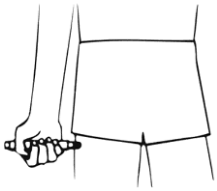
1)
2)
3)

EpiPen® and EpiPen® Jr. Directions

•Pull off gray activation cap.

Hold black tip near outer thigh (always apply to thigh).



Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

Pull off green end cap, then red end cap.

Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
Slide yellow or orange collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

First Administration

Second Administration

Once EpiPen® or Twinject™ is used, call the 911 Emergency. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room or Medical Facility for at least 4 hours.

Release – Consent Form

Angels Academy
5845 Campbellton Road
Atlanta, Georgia 30331

MINOR CHILD PHOTO/VIDEO RELEASE & CONSENT FORM

I/We give permission for our child or children, to be photographed and/or videotaped by Angels Academy Resource Department staff or any media representatives of Angels Academy, LLC in conjunction with school sponsored activities, company Internet or email communication, and social media sites.

I/We hereby transfer to Angels Academy, LLC all copyright and other interests in photographs and/or videotape taken. I/We also hereby grant royalty-free permission; including nonexclusive world rights in all languages; to reproduce in all formats including but not limited to print, electronic, and/or CD-ROM; and to include the likeness of our child or children for school related functions, publications, or promotional purposes only.

Student/Minor Child's Name: _____

Student/Minor Child's Name: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name(s): _____

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Date: _____

Thank you!

Please return this form to:

Angels Academy, LLC
Attention: Human Resources Department
5845 Campbellton Road
Atlanta, Georgia 30331
Phone: (404) 344-2444
Fax: (404) 344-2466

Angels Academy
5845 Campbellton Road
Atlanta, Georgia 30331

Emergency Medical/Contact Information – Transportation Agreement

Child/Student's Last Name **First Name** **Middle Name (Print name as it appears on Birth Certificate)**

Address where student resides **City** **State** **Zip Code**

Age Now **Date of Birth** **Gender** □ Male □ Female

Parent/Legal Guardian Name

Home Address **City** **State** **Zip Code**

Parent/Legal Guardian Name

Home Address **City** **State** **Zip Code**

Home Phone	Father Mother Other	Cell Phone	Father Mother Other	Work Phone	Father Mother Other
	Father		Father		Father
	Father		Father		Father

Person to notify in a medical emergency and/or authorized to pick up our children from school	Address	Contact Phone Number	Relationship
Name:			Father
Name:			Father
Name:			Father
Name:			Father

Child's Doctor, Practitioner	Address	City/State/Zip Code	Phone
Children's Healthcare of Atlanta	35 Jesse Hill Dr. SE	Atlanta, GA 30303	(404) 785-9500
Medical Facility/Hospital (or nearest available)	**Address**	**City/State/Zip Code**	**Phone**

Child's Allergies:
Current prescribed medications:
Child's special needs and conditions:

In the event of an medical emergency involving my child that requires immediate medical attention, and if Angels Academy cannot get in touch with the parents, I/We authorize any **necessary emergency medical care** and **transportation** to the nearest available emergency medical facility. I/We further agree to be fully responsible for all medical expenses incurred related to the medical treatment and/or emergency transportation of my child.

Child's Name:
Parent/Legal Guardian Signature: **Date:**
Witness By: **Date:**

Angels Academy
5845 Campbellton Road
Atlanta, Georgia 30331

Transportation Agreement – After School Program Care

This is to certify that I/We give **Angels Academy, LLC** permission to transport/pick-up my child

Name of Child
from at (am/pm) AM **School or Approved Pick-Up**

to Angels Academy 5845 Campbellton Rd. SW Atlanta, GA 30331 at (am/pm) AM
Destination/Delivery Location

Other Transportation – School Activities:

My child will be transported/picked-up from at (am/pm) AM
to **Location Name of School/Facility)**
at (am/pm) AM

Scheduled Transport/Pick-up Day

Monday_____
Tuesday_____
Wednesday_____
Thursday_____
Friday_____

Angels Academy Staff are authorized to pick-up and transport my child. In the event my child will not be available for pick-up at the designated time or Angels Academy is unable to transport/pick-up my child, the following procedures and notification are to be followed:

1) Parent shall notify Angels Academy in advance that the child will not be available for pick-up.

2) Should Angels Academy be unable to transport/pick-up the child, we will attempt to notify the Parent/Legal Guardian through the contact phone numbers provided at enrollment and on file.

In the event that my child is not to be transported or picked-up as outlined above, I/We agree to provide advance notification to Angels Academy prior to the scheduled transportation/pick-up time.

Parent/Legal Guardian Signature: _____ **Date:**

Parent/Legal Guardian Signature: _____ **Date:**

Angels Academy
5845 Campbellton Road
Atlanta, Georgia 30331

This Form Must Be Signed and Dated by All Parents

Parent and Student Handbook – 2025–2026

- RECEIPT -

The Parent and Student Handbook summarizes the provisions of the school enrollment, registration, operating guidelines, and policies of Angels Academy, LLC. Read the Handbook and all attachments carefully.

I/We have received and will carefully read the Angels Academy **2025–2026** Parent and Student Handbook in advance of my/our child's school attendance. I/We agree to comply with all policies and procedures contained in the Angels Academy Parent and Student Handbook and attachments.

In addition to the Parent and Student Handbook, I/We have also completed, received, and read the following attachments included in the Parent and Student Registration Package:

1) Student Enrollment Application Form – Personal Information
2) Student Medical History – Emergency Treatment
3) Parent-Provider Tuition Service Contract – 2025-2026*
   *Tuition Service Contract Terms/Student and Family Contract Information completed by School Office
   Signed and Returned Contract required prior to student enrollment.
4) Tuition Programs and Fee Schedule – 2025-2026
5) Tuition Express Automatic Payment Application
6) Uniform Shirt Order Form
7) Food Program – Income Eligibility Statement [IES]
8) Request for School Meal Accommodation – Physician's Prescription for Food Allergy
9) Photo/Video Release Policy Form
10) Emergency Medical – Child Transportation Agreement
11) School Curriculum Plan – Current School Semester

By signing this form, I acknowledge that I/We have completed, received, and reviewed the school enrollment application, Parent and Student Handbook, and all other attachments included in the Parent and Student Registration Package as listed above.

Printed Name **Date** **Printed Name** **Date**

Student Name

_____ _____

Parent/Legal Guardian Signature **Parent/Legal Guardian Signature**

Angels Academy Representative

Student Name

_____ _____

Printed Name **Date**
Signature

_____

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Fax: (404) 344-2466