

STEPPING STONES
EDUCATIONAL THERAPY CENTER
EST. 1990

February 16, 2024

Dear Preschool Parents:

We are excited to offer you an enrollment application for your rising PreK-4 student for the 2024-2025 school year. Stepping Stones Educational Therapy Center remains steadfast in its mission to offer a reverse inclusion preschool that serves to not only provide critical early intervention education for our students with diagnosed needs, but to also offer an experiential, robust, developmentally appropriate curriculum that empathizes growth of the body, mind, and spirit. Stepping Stones preschool students gain not just an education, but also a social and emotional foundation upon which to build their future educational endeavors that will help them BLOOM. Thank you for allowing us to partner with your family in your child's early childhood education.

Please note the following dates as they pertain specifically to the Georgia DECAL Lottery Funded PreK-4 program:

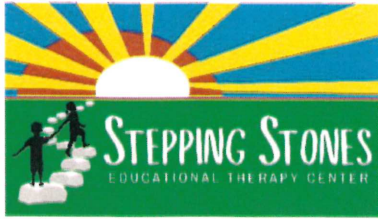
1. The application deadline for consideration in the PreK-4 lottery drawing is **MONDAY, MARCH 4, 2024**
2. Seat drawings will be held on **FRIDAY, MARCH 8, 2024**
3. Parents will be notified of their child's status on **MONDAY, MARCH 11, 2024**

To be considered for the Georgia Lottery Funded PreK-4 program drawing, it is critical that you submit **ALL DOCUMENTAION BY THE MARCH 4 DEADLINE. Incomplete applications will NOT be eligible for the drawing.**

Please reach out to Emily Johns at e.johns@steppingstonesschool.org or Alyssa Lynch at alynch@steppingstonesschol.org if you have any questions or need assistance with the application process. Thank you for trusting your child's early childhood education to Stepping Stones Educational Therapy Center.

Take care,

Erin C. Mulder
Executive Director
Stepping Stones Educational Therapy Center
e.mulder@steppingstonesschool.org



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Phone: 770-229-5511
Fax: 770-233-0995
Email: info@steppingstoneschool.org

PreK-4 APPLICATION FOR ADMISSION

Date of Application: _____ Social Security Number: _____

Name of Applicant: _____
(Last) (First) (Middle) (Preferred)

Date of Birth: _____ Current Age: _____

Gender: _____ Ethnicity: _____

Child's Primary Language: _____ Is student Hispanic/Latino? YES NO

Current School (if applicable): _____

Has the applicant been diagnosed with a learning difference or impairment? _____

If yes, BRIEFLY please list diagnosis(es): _____

Application Checklist

Please remit all requested items with the application form

_____ Application form _____ Recent picture of child _____ Immunization Records _____ Copy of Insurance Card

_____ 2 items verifying proof of residency _____ Copy of Parent/Guardian Photo ID

_____ Copy of Form 3300 (Ear, Eye and Dental) _____ Birth Certificate _____ Social Security Card

If Applicable:

_____ School Transcripts _____ Most Recent Behavioral Assessment _____ Current IEP

_____ Records Release Authorization Form _____ Current Feeding Plans, Medical Plans, Seizure Plans

_____ Copy of Psychological, Neurological, Speech, and Language Reports

Household Information

Please note that this information applies ONLY to parents/guardians who reside in the same household as the student. If there is a second household, or another parent who shares custody, they will update their own household information separately.

Parent/Guardian:

Full Name: _____

Relationship to Student: _____

Address: _____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Student resides with (please circle all that apply): Mother Father Guardian Grandparent Stepparent

Name and ages of siblings, if applicable: _____

Emergency Contact, other than custodial guardian/parent: _____

Cell Phone: _____ Email: _____

Address: _____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

In the event of an emergency, I give Stepping Stones Educational Therapy Center permission to share the applicant's information with the aforementioned person(s) listed under parent/guardian and emergency contact.

Signature: _____ Date: _____

Authorized Pick Up

In addition to parents/guardians, please list all people who are authorized to pick up student(s). Please note that the school reserves the right to confirm the identity of authorized persons by requesting photo identification at the time of pick up.

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Photo Release Consent

Use of Photographs – Please check ONE:

I give consent to the use, publication, and copyright by Stepping Stones Educational Therapy Center in school publications, website, school and classroom social media platforms, and other promotional materials, artwork, written work, videos or photographs in which the above student may appear in any programs or activities of Stepping Stones Educational Therapy Center. This consent includes the use of photographs of student(s) in the local newspaper, and authorizes the student's name to appear in the paper with press releases of activities at Stepping Stones Educational Therapy Center. The foregoing consent shall extend beyond the student's enrollment and shall survive the termination of this contract.

I **DO NOT** give consent to the use, publication, and copyright by Stepping Stones Educational Therapy Center in any school publications, website, school and social media platforms, and other promotional materials, artwork, written work, videos or photographs in which the above student may appear in any programs or activities of Stepping Stones Educational Therapy Center. The foregoing consent shall extend beyond the student's enrollment and shall survive the termination of this contract.

Signature: _____

Date: _____

Medical History and Information

Name of Pediatrician: _____ Phone Number: _____

Address: _____

Student Insurance Company: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Does student have any medical conditions? YES NO

If yes, please list: _____

Please list all medications:

Medication #1: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #2: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #3: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #4: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #5: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Permission for Nurse to Administer Over-the-Counter medications as needed (dosage will be administered based on child's weight and age):

Tylenol/Acetaminophen

Advil/Ibuprofen

Tums

Cough Drops

Please list any allergies:

Has your child been seen by an Occupational, Speech/Language, Physical, or ABA Therapist(s): YES NO
If yes, please list the name of therapist, type of therapy, and phone number of provider:

Medical Authorization and Parental Consent: In the event the above named child becomes ill or sustains injury while at school or any other school related trip or event at Stepping Stones Educational Therapy Center. I, the undersigned, give my permission to those in charge to take whatever steps are necessary to stop any bleeding and to administer first aid. I, also, consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the above-named minor under the general or special supervision and on the advice of any duly licensed physician, surgeon, and/or dentist, whether such diagnosis or treatment is rendered at the office of said physician, surgeon, or dentist or at a licensed hospital. The undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for the aforementioned child to return home due to medical reasons, behavioral problems or otherwise, the undersigned agrees to assume all transportation costs. The undersigned does also, hereby, give permission for the above named child to ride in any vehicle designated by the adult in whose care the minor has been entrusted, provided the child is in a safety belt and, if available, a shoulder strap while attending and participating in the activities sponsored by Stepping Stones Educational Therapy Center.

Signature: _____

Date: _____

Educational History

(If applicable)

Current School/Institution: _____

Grade/Class: _____ Does student have a current IEP/504/Service Plan: YES NO

Address: _____

Phone Number: _____

Current Services Provided By School/Institution: _____

Please list, beginning with most recent, all schools applicant has attended (if applicable):

School/Institution: _____ Dates Attended: _____

Address: _____

Phone Number: _____

Reason for Leaving: _____

School/Institution: _____ Dates Attended: _____

Address: _____

Phone Number: _____

Reason for Leaving: _____

Has there been any difficulties with student's behavior in a school/institution setting? If so, please explain:

Parent/Student Handbook Acknowledgement

I acknowledge that Student/Parent Handbook has been made available to me on the school website (www.stepsstoneschool.org) and in paper format: I will review it with my student.

Signature: _____

Date: _____

Acknowledgement of School Operating Hours

I acknowledge that Stepping Stones Educational Therapy Center school hours are 8:05 am to 3:05 pm, Monday through Friday, as indicated by the school calendar. That before and after care is available to me as needed.

Signature: _____

Date: _____

Acknowledgement of Attendance Policy

I acknowledge that the Stepping Stones Educational Therapy Center Lottery Funded Pre-K4 Program must adhere to all state polices and regulations regarding attendance. **Excessive unexcused absences and/or tardies may result in my student's dismissal from the program.**

Signature: _____

Date: _____

Notice of Nondiscrimination Policy

Stepping Stones Educational Therapy Center admits students of any race, color, national or ethnic origin, to all rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate based on color, race, national or ethnic origin in the administration of its educational policies, admission policies, athletics and other school-administered programs.

Tuition and Fees:

Georgia Lottery Funded PreK-4 Program: FREE, pending eligibility of student attendance per DECAL's GA Lottery Funded Pre-K program.

Afterschool Fees: Afterschool is billed as needed at a flat rate of \$50 per week, per child.

Meals: Meals are \$50 per month: this includes breakfast, lunch and snacks. Free and reduced meal applications are available.

Contract for Enrollment Terms and Conditions

The information provided in this application is to the best of my knowledge complete, accurate, and true. I understand that the application fee must be paid before a child is enrolled and that it is non-refundable. **I understand that before my child can be entered into the Georgia Lottery Funded PreK4 seat drawing, I understand that all required documents must be turned into the school office.** I understand that in signing this Contract for the coming school year, I am agreeing to accept the policies and procedures of Stepping Stones Educational Therapy Center as established by the Board of Directors and/or the Administration of the school, the policies and procedures as set forth in the school's handbook(s), and the financial terms and conditions described to me in the financial portion of the enrollment process. This Contract should be signed by both Parents (and/or guardians/conservators).

Signature: _____ *Date:* _____

Printed Name: _____ *Relationship to Student:* _____

Signature: _____ *Date:* _____

Printed Name: _____ *Relationship to Student:* _____

Additional Information

The following is only to be completed if applicant has a suspected or diagnosed learning difference or disability.

Developmental History

Name of Student: _____ Birthdate: _____

Age when student:

Sat: _____ Crawled: _____ Walked: _____ Talked: _____ Used Full Words: _____ Used Full Phrases: _____

Academic Skills: The following questions are related to pre/academic information. For each item below, please write "I" if the students can complete the task independently, or, "A" if the student can complete the task with assistance (verbal or otherwise). If student cannot complete the task as of yet, please leave blank.

_____ Complete simple interlocking puzzles _____ Complete basic patterns _____ Match photos

_____ Identify colors _____ Identify shapes _____ Identify letters _____ Spell first name _____ Spell last name

_____ Rote count 1-10 _____ Rote count 1-20 _____ Rote higher than 20 _____ Identify numbers 1-10

_____ Identify numbers higher than 11-20 _____ Identify numbers higher than 20 _____ Write name

_____ Write words _____ Reads sight words _____ Reads phonetically _____ Comprehends what is read

_____ Complete basic math functions with single digits _____ Complete basic math functions with two digits

_____ Write in phrases _____ Write in complete sentences

If academic skills exceed those listed above, please describe: _____

Student's favorite subjects, interests, or topics: _____

Student's strengths both in and outside the classroom: _____

Functional Skills: The following questions are related to daily functioning, fine and gross motor skills. For each item below, please write "I" if the students can complete the task independently, or, "A" if the student can complete the task with assistance (verbal or otherwise). If student cannot complete the task as of yet, please leave the item blank.

_____ Pick up small items with fingers _____ Manipulate objects with both hands _____ Throw a ball

_____ Use stairs _____ Run _____ Jump _____ Use slide _____ Put on most items of clothing

_____ Take off most clothing _____ Use buttons _____ Use zippers _____ Tie laces _____ Wash Hands

_____ Brush teeth _____ Comb/brush hair _____ Bathe or shower _____ Eat with fork and/or spoon

_____ Drink from a regular cup _____ Use computer _____ Use writing utensil _____ Draw

_____ Play appropriately with toys _____ Play appropriately with others _____ Shows interest in others actions

Is student toilet trained? YES NO

If no, has student begun toilet training? YES NO If yes, please give date started: _____

Can student indicate when they need to use the restroom? YES NO

Social/Emotional History

Please describe how student interacts with parents/guardians and siblings:

Please describe how student interacts with peers:

Has the student ever exhibited impulsive and/or aggressive behavior? YES NO If yes, please describe:

Does student have a behavior plan at their current school/institution? YES NO If yes, please describe:

Does student exhibit anxiety? YES NO If yes, please describe how the school can best help student feel more comfortable in the educational setting:

Diagnosis: Please list all student's diagnoses, and dates made. Please be sure to include any cognitive, physical, mental, social/emotional, and/or medical diagnoses. Please attach supporting documents, if available.

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Injuries/Illness: Please list any significant past injuries, surgeries, or extended illnesses.

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Is student currently medically stable: YES NO

If no, please explain: _____

Has your child ever had a seizure? YES NO If yes, please explain: _____

If yes, does student have a current seizure plan: YES NO

If yes, date of last review of plan: _____

If yes, please attach copy of plan to packet.

Has the student ever been seen by a Psychiatrist, Psychologist, or Counselor? YES NO

Date of most recent psychological: _____

Has the student ever been seen by a developmental pediatrician or neurologist? YES NO

Has child ever been seen by a specialist other than those mentioned above? YES NO

If yes to any of the aforementioned questions, please explain reasons for visit and diagnosis (if applicable):

Dietary Concerns: Please list any dietary needs (diet, allergies, aversions, chewing/swallowing concerns, etc.) of which our staff needs to be aware:



Georgia Department of Early Care and Learning

Please write
the school
year in the
box →

Pre-K Registration Form

School Year

2024-2025

PROVIDER LEGAL NAME: Stepping Stones Educational Therapy Center (This section to be completed by the provider)

SCHOOL/SITE NAME: Stepping Stones Educational Therapy Center

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 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:	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/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 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: <input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER			
CHILD'S LEGAL GUARDIAN: <input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER			
THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:			
<u>NAME</u>	<u>ADDRESS</u>	<u>RELATIONSHIP</u>	<u>CELL PHONE</u>
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:			

Please do not leave any section blank. If the section does not apply to your child, please write "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: _____

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, _____, 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.

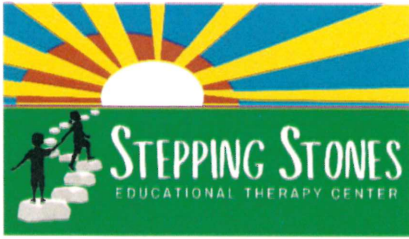
The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising 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: _____



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EST. 1990

Proof of Residency- Please provide one proof from each list. If proofs are in a Spouse's name a Marriage License is required.

ONE OF THE FOLLOWING:

- Copy of mortgage statement/payment – dated with name and address - current within 30 days.
- Copy of current property tax bill/statement of value.
- Copy of rental agreement– this must include the address, names of people living in the house, the name of the leaseholder/company, expiration date, and signatures.

Further examples of proof of residency include the following (you only need one of the following):

- current lease
- property tax note
- homeowner's insurance bill
- mortgage statement
- current vehicle registration form
- letter from shelter
- letter from employer if employer provides housing
- any utility bill listing the residence as the service address
- current PeachCare eligibility documents (PeachCare card or eligibility letter) for the child
- if your family is living with someone else, you can provide a notarized affidavit from the property owner stating where the child's family is residing, plus a copy of the property owner's proof of residency (any items listed above).
- active duty military families can support Georgia residency with a copy of official military orders verifying Georgia residency during the school year

AND ONE OF THE FOLLOWING:

- Copy of utility service contract or bill, landline telephone bill, cable TV or internet bill - date, name, and address must appear on the statement and must be dated within 30-45 days. Unfortunately, a cell phone bill will not be accepted.
- Copy of homeowner's insurance policy/receipt- must be dated and show name and address.
- Income tax form with address - current year ONLY with valid photo ID of the legal parent/guardian, proof of custody/guardianship if a person other than the natural parent is registering the child. Legal proof of guardianship is needed (i.e. court documents or DFACS papers).