



STEPPING STONES  
EDUCATIONAL THERAPY CENTER  
EST. 1990

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

**NOTE: Partial applications will not be accepted.**

## 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: \_\_\_\_\_

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**Optional Additional Emergency Contact, other than custodial guardian/parent:** \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

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**Optional Additional Emergency Contact, other than custodial guardian/parent:** \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

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*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.

**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:

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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:

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**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.steppingstonesschool.org](http://www.steppingstonesschool.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 **8:00 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 policies 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 on an as needed basis at a rate of \$10 per day, per child. Late pickup will result in a fee of \$25 for the first five minutes late, \$1 per minute thereafter, until the student has been picked up.

**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 2026-2027 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:

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Please describe how student interacts with peers:

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

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

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

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**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:

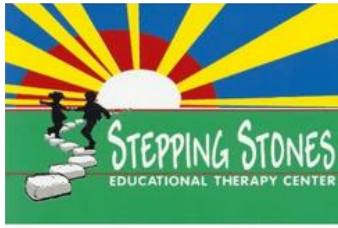
\_\_\_\_\_  
\_\_\_\_\_

## Proof of Residency Examples

Proof of Residency- is a legal document that confirms your name and where you live

### **ANY TWO OF THE FOLLOWING:**

- current lease
- property tax note
- homeowner's insurance bill
- mortgage statement
- current vehicle registration form
- letter from shelter
- any utility bill listing the residence as the service address such as water, gas, electricity, internet or cable tv.
- 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. 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, cell phone bills will not be accepted.



## **STEPPING STONES EDUCATIONAL THERAPY CENTER KEY DATES 2026-2027**

Preplanning	July 30-31, August 3-5
Open House	Tuesday, August 4
First Day of School	Thursday, August 6
Parent Teacher Conferences	Tuesday, August 25 – Thursday, August 27
Labor Day (No School)	Monday, September 7
Grand-friends Day	Friday, October 9 (11:30 Dismissal, NO ASP)
End of 1 <sup>st</sup> 9 weeks of school	Friday, October 9
Fall Break	Monday, October 12 – Friday, October 16
Thanksgiving Break	Monday, November 23 – Friday, November 27
Christmas Program and Class Parties	Friday, December 18 (11:30 Dismissal, NO ASP)
End of 2 <sup>nd</sup> 9 weeks of school	Friday, December 18
Christmas Break	Monday, December 21 – Monday, January 4
Teacher In-service	Monday, January 4
Classes Resume	Tuesday, January 5
MLK Holiday	Monday, January 18
Winter Break	Monday, February 15 – Friday, February 19
Academy Prom	Friday, March 5 (No after school; 3:05 Dismissal, NO ASP)
Saralyn Fountain Day	Thursday, March 11
End of 3 <sup>rd</sup> 9 weeks of school	Friday, March 13
Field Day	Friday, April 2
Spring Break	Monday, April 5 – Friday, April 9
Academy Honors Celebration	Friday, May 14
Last Day of School/End of 4 <sup>th</sup> 9 weeks of school	Tuesday, May 25 (11:30 Dismissal, NO ASP)
Post-planning	Tuesday, May 25 (11:30-3:00) – Friday, May 28
Memorial Day Holiday	Monday, May 31

# STEPPING STONES EDUCATIONAL THERAPY CENTER

## 2026-2027 CALENDAR

July 30, 31: New Teacher Orientation  
 August 3-5: Professional Development  
 August 4: Open House  
 August 6: First Day of School

AUGUST 2026						
S	M	T	W	Th	F	S
	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY 2027						
S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

February 15-19: Winter Break

September 7: Labor Day Holiday

SEPTEMBER 2026						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MARCH 2027						
S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

March 5: Academy Prom, No ASP

October 9: Grandfriends Day, 11:30 am dismissal, No ASP  
 October 12-19: Fall Break

OCTOBER 2026						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

APRIL 2027						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

April 5-9: Spring Break

November 23-27: Thanksgiving Break

NOVEMBER 2026						
S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

MAY 2027						
S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

May 25: Last Day of School, 11:30 am Dismissal, No ASP, Teacher Workday  
 May 26-29: Post-Planning  
 May 31: Memorial Day Holiday

December 18: Christmas Program and Class Parties, 11:30 am Dismissal, No ASP  
 December 21-31: Christmas Break

DECEMBER 2026						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

JUNE 2027						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

January 1: New Year's Day Holiday  
 January 4: Teacher Work Day, No School for Students  
 January 5: Classes Resume  
 January 18: MLK, Jr. Day Holiday

JANUARY 2027						
S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

JULY 2027						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

July 5-10: 4th of July Holiday, Office Closed





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