

**God's Bright Treasures Ministry, Inc.**  
 25365 State Line Road  
 Lawrenceburg, IN 47025  
 PH: (812) 637-6830 FAX: (812) 637-1892  
*Growing in the Light of the Son!*

FOR OFFICE USE ONLY			
1. \$65 Application Fee Rec'd	Date _____	Ck# _____	
2. Advance Tuition Rec'd	Date _____	Amt. _____	Ck# _____
3. \$25 Supply Fee Rec'd	Date _____	Ck# _____	
4. Immunization History Rec'd	Date _____	Early Entrance _____	
5. Birth Certificate Rec'd	Date _____	Start Date _____	

**GBT 1/2 Day Preschool from Labor Day 2010-Memorial Day 2011**

**STUDENT ENROLLMENT APPLICATION**

Please complete a separate application for each child you wish to enroll. Return the completed form(s) with a check payable to God's Bright Treasures in the amount of **\$90 for each application. This application fee is non-refundable.**

**STUDENT INFORMATION** (Please print)

Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Gender:  F  M Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Age on August 1<sup>st</sup>: years \_\_\_\_ months \_\_\_\_ Preferred Name to be used in the classroom \_\_\_\_\_

Has your child attended GBT before? Yes No List other schools your child has attended. \_\_\_\_\_

With whom does the student live?  Both Parents  One Parent  One Parent deceased  Parent & Step-parent  
 Guardian  Other, please explain \_\_\_\_\_

Was English the **first** language spoken by this child? Yes No If No, what was the first language spoken? \_\_\_\_\_

Ethnicity (Check One)	
<input type="checkbox"/> 01-Indian/Alaskan Native	<input type="checkbox"/> 04-Hispanic
<input type="checkbox"/> 02-African American	<input type="checkbox"/> 05-White
<input type="checkbox"/> 03-Asian/Pacific Islander	<input type="checkbox"/> 06-Multi-Ethnic

**PARENT / LEGAL GUARDIAN INFORMATION** E-Mail Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Street Address: \_\_\_\_\_ Street Address \_\_\_\_\_  
 (List address if different from above.)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Father's Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

May we call you at work? Yes No Emergency Only May we call you at work? Yes No Emergency Only

\*\*\*\*\*

**GUARDIANSHIP:** (Circle One) Guardian's Name \_\_\_\_\_

PARENTS MOTHER FATHER Street Address \_\_\_\_\_

DIVORCED: JOINT GUARDIANSHIP City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

OTHER: \_\_\_\_\_ Day Phone \_\_\_\_\_

RESTRICTIONS: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

---

## EMERGENCY & TRANSPORTATION INFORMATION

List the name and phone number of the primary person(s) who will be picking this child up from school on a normal basis.

1. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship
2. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship

In Case of an **Emergency**, and Parents cannot be contacted, call one of the following (List in order of preference; may be one of the above.)

1. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship
2. \_\_\_\_\_  
Daytime Phone Number                      Name                      Relationship

CHILD'S DOCTOR: \_\_\_\_\_ DOCTOR'S PHONE: \_\_\_\_\_

CHILD'S DENTIST: \_\_\_\_\_ DENTIST'S PHONE: \_\_\_\_\_

---

## Consent for Treatment

In the event a child incurs a major injury while at God's Bright Treasures, the local emergency squad will be called. The EMT will decide whether they can administer treatment at the center/ school or whether the child should be transported to the nearest hospital for emergency care.

### Permission to Transport Child:

I give God's Bright Treasures Ministry, Inc. permission to have my child, \_\_\_\_\_  
Name of child  
Transported by ambulance to \_\_\_\_\_ Hospital for emergency medical care  
Name of Hospital  
and / or to \_\_\_\_\_ for emergency Dental care, or the nearest available source of  
Dentist Name  
assistance.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Permission for Analgesics, Benadryl

God's Bright Treasures is hereby given permission to administer the medication Diphenhydramine/Benadryl by mouth to my child, according to the dosage outlined, in the event that my child is stung by a bee or wasp at school. *The recommended doses are based on a child's weight (20-40 lbs., 1tsp, 40-60 lbs., 1 1/2 tsp, 60-190 lbs., 2tsp) and administered every 6 hours. Please circle weight and dosage.*

Check those below that you give your permission for God's Bright Treasures to administer as needed and outlined below.

\_\_\_\_ Acetaminophen (i.e. Tylenol) every 4 hours (based on age/wt)      \_\_\_\_\_ Ibuprofen every 6 hours (based on age/wt)

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Health Record

\*\*\*\*\*

### Check health conditions that affect your child.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma (Mild / Moderate / Severe) | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Diabetic disorder |
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Tubes in the ear        | <input type="checkbox"/> Heart Condition   |
| <input type="checkbox"/> Bee Sting Allergy                 | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Visual Impairment |

Other: \_\_\_\_\_

**Medical Update:** Please inform us of your child's current health condition, such as allergies, asthma, vision problems, broken bones, physical handicaps, and recent surgeries, hospitalization, injuries or other illnesses.

Allergies: \_\_\_\_\_

List all allergies and any special precautions and treatment indicated for these allergies: (e.g., food, medication or environmental allergies).

Chronic: \_\_\_\_\_

List any chronic physical problems and any history of hospitalization

Other: \_\_\_\_\_

Does your child require a special diet due to medical reasons? Yes No Explain: \_\_\_\_\_

Does your child require the use of an inhaler or nebulizer treatment on a regular basis? Yes No  
Explain: \_\_\_\_\_

\*\*\*\*\*

**Medications:** Please list your child's medications and reasons for taking them.

Medication	Dose	Frequency	Reason
------------	------	-----------	--------

1. \_\_\_\_\_

2. \_\_\_\_\_

Most medications may be taken at home. Will this student be required by a physician to take medication during school hours?  No  Yes If Yes explain: \_\_\_\_\_

\*\*\*\*\*

### Home and Family

Older Siblings: \_\_\_\_\_ Age \_\_\_\_\_ Younger Siblings \_\_\_\_\_ Age \_\_\_\_\_

Older Siblings: \_\_\_\_\_ Age \_\_\_\_\_ Younger Siblings \_\_\_\_\_ Age \_\_\_\_\_

Older Siblings: \_\_\_\_\_ Age \_\_\_\_\_ Younger Siblings \_\_\_\_\_ Age \_\_\_\_\_

Does your family have a home church? Yes No If yes, where? \_\_\_\_\_

Do you or your family members have talents, careers or interest can be shared with our children? \_\_\_\_\_

\*\*\*\*\*

\*\*\*\*\*

**Language Development & Learning Needs**

Does your child receive speech therapy? No Yes Where? \_\_\_\_\_

Has your child been diagnosed with ADD/ADHD or other learning difficulty? \_\_\_\_\_

\*\*\*\*\*

**Education, Social and Development History**

Is this your child’s first experience within an educational or daycare setting? Yes No

# years at GBT \_\_\_\_\_ Other daycare centers/schools attended \_\_\_\_\_ # years \_\_\_\_\_

How would you generally characterize your child? Very Outgoing \_\_\_\_\_ Usually Friendly \_\_\_\_\_

Happy \_\_\_\_\_ Solemn \_\_\_\_\_ Shy \_\_\_\_\_ Boisterous \_\_\_\_\_

Other \_\_\_\_\_

Favorite play materials \_\_\_\_\_

Special interests \_\_\_\_\_

Favorite foods \_\_\_\_\_

Does the child have any special fears? Please explain and include any details that may help us fully understand:

\_\_\_\_\_

Was the child born prematurely or in any other unusual circumstance? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Is the child using diapers during the day? \_\_\_\_\_ For nap? \_\_\_\_\_ At night? \_\_\_\_\_

Which does the child prefer to use? Complete sentences \_\_\_\_\_ Phrases \_\_\_\_\_ 1 or 2 words \_\_\_\_\_ Sounds \_\_\_\_\_

Can your child be understood by Parents? \_\_\_\_\_ Siblings? \_\_\_\_\_ Playmates? \_\_\_\_\_ Strangers? \_\_\_\_\_

Sleep Habits \_\_\_\_\_

---

**School Accreditation**

In 2008, God’s Bright Treasures Academy became accredited through the Indiana Department of Education. Some funding opportunities require data that tells us the social economic background of our students based on a system used in the public schools for identifying students qualifying for reduced or free lunches. You can help us gather this information by answering the questions below. This information will be kept confidential.

*Circle Yes or No in response to each question.*

1. My family is receiving Food Stamps or “Temporary Assistance for Needy Families” (TANF). **Yes No**
  2. My household’s income is at or below the level shown on the income scale from “Household Size & Income Eligibility Guidelines” in accordance with federal law and U.S. Department of Agriculture policy. (See page 7 for eligibility guidelines) **Yes No**
-

\*\*\*\*\*

**Parent / Student Handbook Acknowledgement**

I/We, \_\_\_\_\_, the parent(s) / legal guardian(s) of \_\_\_\_\_, acknowledge that I/we have received a copy of God’s Bright Treasures Ministry, Inc.’s Parent Handbook and have been given the opportunity to read the manual and ask questions about and understand the policies contained therein. Furthermore, I/we agree to abide by the policies set forth in the manual.

I/We understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between GBT and the parents. GBT reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Print Name \_\_\_\_\_

\*\*\*\*\*

**Program Preferences** (please note your preferences 1, 2)

Your child will be placed in either a morning or afternoon class as we strive to create balanced classrooms that facilitate the best learning environment. However, if you have a strong need for one or the other time slots, please check the preferred time slot and explain your need.

Morning Session 8:15 – 11:15 am

OR

Afternoon Session 12:00 – 3:00 pm

Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

**Please tell us where your child is to go after class.**

Home       Babysitter       Carpool       Other \_\_\_\_\_

\*\*\*\*\*

**Please use this space to communicate any other helpful information or expectations:**

## Fee Agreement

### **½ Day Beginners Total Fees \$990 – Orientation is September 7, Classes start September 9**

- \$65 Registration\* – due with Enrollment Application
- \$25 Annual Supply Fee\* – due with Enrollment Application
- Downpayment of \$100 due by July 31, 2010\* (will be applied to May 2011 tuition)
- Monthly tuition is due prior to the 1<sup>st</sup> class of each month.
  - \$100 – due September
  - \$100 – due October
  - \$100 – due November
  - \$100 – due December
  - \$100 – due January
  - \$100 – due February
  - \$100 – due March
  - \$100 – due April

My signature confirms my agreement to pay God’s Bright Treasures Ministry, Inc fees as stated above.

\_\_\_\_\_  
Parent/legal guardian signature

Date \_\_\_\_\_

### **½ Day Pre-Kindergarten Total Fees \$1,170 – Orientation is September 8, Classes start September 10**

- \$65 Registration\* – due with Enrollment Application
- \$25 Annual Supply Fee\* – due with Enrollment Application
- Downpayment of \$120 due by July 31, 2010\* (will be applied to May 2011 tuition)
- Monthly tuition is due prior to the 1<sup>st</sup> class of each month.
  - \$120 – due September
  - \$120 – due October
  - \$120 – due November
  - \$120 – due December
  - \$120 – due January
  - \$120 – due February
  - \$120 – due March
  - \$120 – due April

\_\_\_\_\_  
Parent/legal guardian signature

Date \_\_\_\_\_

\*Registration, Annual Supply Fee, and Downpayment are non-refundable.

## Household Size & Income Eligibility Guidelines\*

**Effective from July 1, 2008 to June 30, 2009**

The following household size and income criteria will be used for determining eligibility for free and reduced-price meals through the National School Lunch, School Breakfast and Special Milk programs. These programs assist families who are unable to pay the full price for meals and milk served in schools.

<b>Reduced-Price Meals</b>				<b>Free Meals</b>		
<i>185% of federal poverty guidelines</i>				<i>130% of federal poverty guidelines</i>		
Household Size	Yearly	Monthly	Weekly	Yearly	Monthly	Weekly
1 person	\$19,240	\$1,604	\$370	\$13,520	\$1,127	\$260
2 people	\$25,900	\$2,159	\$499	\$18,200	\$1,517	\$350
3 people	\$32,560	\$2,714	\$627	\$22,880	\$1,907	\$440
4 people	\$39,220	\$3,269	\$755	\$27,560	\$2,297	\$530
5 people	\$45,880	\$3,824	\$883	\$32,240	\$2,687	\$620
6 people	\$52,540	\$4,379	\$1,011	\$36,920	\$3,077	\$710
7 people	\$59,200	\$4,934	\$1,139	\$41,600	\$3,467	\$800
8 people	\$65,860	\$5,489	\$1,267	\$46,280	\$3,857	\$890
For each additional person:	+6,660	+555	+129	+4,680	+390	+90

\*For the 48 Contiguous United States, District of Columbia, Guam and Territories

**NOTE:**

- Households should answer all applicable questions on the form. An application that does not contain all the required information cannot be processed and approved by the school.
- The information on the application for free or reduced-price meals may be verified by the school or other officials at any time during the school year.
- The information households provide will be treated confidentially and will be used only for the eligibility determinations and verification of data.

**REQUIRED INFORMATION:**

- **FOOD STAMP / TANF HOUSEHOLDS:** If a household currently receives Food Stamps or "Temporary Assistance for Needy Families" (TANF) for their child, they need only to list the child's name and Food Stamp or TANF case number and sign the application.
- **ALL OTHER HOUSEHOLDS:** If a household's income is at or below the level shown on the income scale, children are eligible for free or reduced-price meals or free milk. Households must provide the following information: (1) the names of all household members, (2) all household income last month and source of income received by each household member (for example, EARNINGS, WELFARE, PENSION or OTHER). Income is all money before taxes or anything else is taken out, (3) the signature of an adult household member and (4) the Social Security number of the adult signing the application.

Households have the right to a fair hearing which may be initiated by contacting the hearing official in the local school corporation.

*In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, sex, color, national origin, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call 202-720-6382 (voice and TDD). USDA is an equal opportunity provider and employer.*

