



ADMISSION INFORMATION

Purpose: Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

GENERAL INFORMATION

Operation's Name:		Director's Name:	
Child's Full Name:	Child's Date of Birth:	Child Lives With: <input type="checkbox"/> Both parents <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Guardian	
Child's Home Address:			
Date of Admission:		Date of Withdrawal:	
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian (if different from the child's):	
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File: <input type="checkbox"/> Yes <input type="checkbox"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached:			Relationship:
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name and Phone Number:	Name and Phone Number:	Name and Phone Number:	

CONSENT INFORMATION

CHECK ALL THAT APPLY:

1. TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care
 ☐ on field trips
 ☐ to and from home
 ☐ to and from school

2. FIELD TRIPS

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trips.

Comments:

3. WATER ACTIVITIES

I give consent for my child to participate in the following water activities:

☐ water table play
 ☐ sprinkler play
 ☐ splashing/wading pools
 ☐ swimming pools
 ☐ aquatic playgrounds

CONSENT INFORMATION

CHECK ALL THAT APPLY:

4. RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including those for:

<input type="checkbox"/> Discipline and guidance	<input type="checkbox"/> Procedures for release of children
<input type="checkbox"/> Suspension and expulsion	<input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Emergency plans	<input type="checkbox"/> Procedures for dispensing medications
<input type="checkbox"/> Procedures for conducting health checks	<input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Safe sleep	<input type="checkbox"/> Meals and food service practices
<input type="checkbox"/> Procedures for parents to discuss concerns with the director	<input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Procedures for parents to participate in operation activities	<input type="checkbox"/> Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

5. MEALS

I understand that the following meals will be served to my child while in care:

☐ None
 ☐ Breakfast
 ☐ Morning snack
 ☐ Lunch
 ☐ Afternoon snack
 ☐ Supper
 ☐ Evening snack

6. DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Phone Number:
Name of Emergency Care Facility:	Address:	Phone Number:
I give consent for the facility to secure any and all necessary emergency medical care for my child.		Signature - Parent or Legal Guardian

CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature - Parent or Legal Guardian:

Date Signed:

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:

School Phone Number:

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

ADMISSION REQUIREMENT

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Health Care Professional's Signature:

Date Signed:

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:

Date Signed:

REQUIREMENTS FOR EXCLUSION

- ☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- ☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

VISION EXAM RESULTS

R 20/	L 20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Signature:		Date Signed:	

HEARING EXAM RESULTS

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature:			Date Signed:	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose) 1–2 months (second dose) 6–18 months (third dose)	
Rotavirus	2 months (first dose) 4 months (second dose) 6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose) 4 months (second dose) 6 months (third dose) 15–18 months (fourth dose) 4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Pneumococcal	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose) 4 months (second dose) 6–18 months (third dose) 4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose) 4–6 years (second dose)	
Varicella	12–15 months (first dose) 4–6 years (second dose)	
Hepatitis A	12–23 months (first dose) The second dose should be given 6 to 18 months after the first dose.	

PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature :	Date Signed:
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VARICELLA (CHICKENPOX)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine.

Parent's Signature:	Date Signed:
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ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shtm.

TB TEST (IF REQUIRED)☐ Positive☐ Negative

Date:

GANG FREE ZONE

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our Privacy and Security Policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.

SIGNATURES

Child's Parent or Legal Guardian:

X

Date Signed:

Center Designee:

X

Date Signed:

Child Assessment Form

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?			
How should we respond if he/she has an allergic reaction?			
Does your child have an existing illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?			
Is the medication prescribed for continuous use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Toileting:

Does your child need assistance with toileting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?			
What are your ideas about toilet training?			
How can we best help?			

3. Behavior:

Does your child have any special fears?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?			
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?			
When your child gets upset, what helps him/her calm down?			
What is a good way to distract your child when he/she is having a temper tantrum?			
Are there any particular routines that are particularly helpful at naptime?			

What position is most comfortable for your child when he/she is napping?	
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4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	
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I verify that the above assessment was discussed with the parent(s) of _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent Date Signed

Additional Comments:

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EMERGENCY INFORMATION

NOTE: THIS ENTIRE FORM MUST BE UPDATED SEMI-ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian 1:	Parent/Guardian 2:
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Employer/School:	Employer/School:
Employer/School Address:	Employer/School Address:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Personal Security Pin:	Personal Security Pin:

Name of Person Authorized to Pick-Up Child (daily) _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code Telephone

When parents cannot be reached, list at least two people who may be contacted to pick up in an emergency:

1. Name _____ Relationship _____
Last First
Telephone (H) _____ (W) _____ (Cell) _____

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Relationship _____
Last First
Telephone (H) _____ (W) _____ (Cell) _____

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Relationship _____
Last First
Telephone (H) _____ (W) _____ (Cell) _____

Address _____
Street/Apt. # City State Zip Code

CHILD HEALTH RECORD

Child's Name:	_____	Birth Date:	_____
	Last First Middle		
Name of Parent/Guardian:	_____	Relationship:	_____
Home Address:	_____		
	Street City State Zip		
Home Telephone:	_____		

Dear Parent/Guardian:

All children should have regular health check ups, immunizations and physical exams from birth to 18 years of age.

State law requires you to submit proof of age-appropriate immunizations on the attached Immunization Certificate to Golden Star Learning Academy prior to the child's first day.

This form is partially completed by you and the other portion will be completed by your physician. Please complete prior to your child's first day at the Academy.

PLEASE RETURN THIS COMPLETED FORM TO:

Academy Address: _____

Street

City State Zip Code

Academy Fax Number: _____

HEALTH HISTORY:

Section A: To be completed by parent/guardian

	YES	NO
1. Are you concerned about your child's general health (eating, sleeping habits, posture, teeth, skin, weight, bowel/bladder, etc.)? If Yes, please explain: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes)? If Yes, please explain: _____ Date of last eye examination: ____/____/____ Doctor's Name: _____ Results: _____ Does your child wear glasses or contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, etc.)? If Yes, please explain: _____ Date of last hearing evaluation: ____/____/____ Doctor's Name: _____ Results: _____ Does your child use a hearing aid? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)? If Yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have any allergies (food or medical)? If Yes, please list: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have any other specific illness, disability or other limiting condition(s)? (a) Does this condition require any special health care in the child care facility or school? If Yes, please explain: _____ (b) Has your child been evaluated in such a way that it could help the child care provider or teacher meet his/her health or education needs? If Yes, please explain: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any concerns about your child's behavior or emotional well-being which the child care provider or school should know about? If Yes, what are your concerns? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your child had any of the following? ____Chicken Pox ____Whooping Cough ____ Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has he/she ever had any serious illnesses or hospitalization? If Yes, please explain: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child have any physical disabilities? If Yes, please explain: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

What arrangements can you make for care during illness? _____

How many colds has your child had this past year? _____

How does your child react to an elevated temperature? _____

Please give us any special instructions if the child becomes ill? _____

Is your child on any medications, regularly? If yes, please list medication and reason(s): _____

PARENT'S STATEMENT - PLEASE SIGN AND DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE SECTION B OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS AT GOLDEN STAR LEARNING ACADEMY.

Parent's Signature

Date

ONLY COMPLETE FOR SCHOOL AGE CHILD:

I give my permission _____ School to release _____'s
Name of Child

Parent's Signature

Date

Section B: To be completed by a HEALTH PRACTITIONER

Child's Name: _____

Child's Date of Birth: _____

1. Date of this child's most recent tuberculin test: ____/____/____. Result: ____ Positive ____ Negative.

2. Date of this child's last tetanus shot: ____/____/____

3. This child has the following which may significantly affect his/her child care or educational experience:

COMMENTS

a. Vision problem

☐ YES ☐ NO

b. Hearing problem

☐ YES ☐ NO

c. Speech or language problem

☐ YES ☐ NO

d. Other physical illness or impairment

☐ YES ☐ NO

e. Mental, emotional or behavior problems

☐ YES ☐ NO

f. Developmental delays

☐ YES ☐ NO

g. Allergies

☐ YES ☐ NO

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care/school. ____ YES ____ NO

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school. ____ YES ____ NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. ____ YES ____ NO

If YES, please specify: _____

7. Does this child have any limitations that would effect full participation at the academy? ____ YES ____ NO

If YES, please specify: _____

8. Does the child's physical activity need to be restricted? ____ YES ____ NO

If YES, please specify: _____

9. Does this child require any specialized treatment? ____ YES ____ NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (e.g., braces, crutches, etc.)? ____ YES ____ NO

If YES, please specify what type: _____

Special instructions for use: _____

11. Additional comments: _____

HEALTH ADDENDUM

INSTRUCTIONS TO PARENT:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/Symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I CONDUCTED A PHYSICAL EXAMINATION OF THE ABOVE-NAMED CHILD ON _____ (date)
AND FIND THAT HE/SHE IS / IS NOT MEDICALLY CLEARED TO ATTEND GOLDEN STAR
LEARNING ACADEMY. (Circle One)

Name of Health Practitioner (Signature)

()

Telephone Number

PARENT AUTHORIZATION AND CONSENT

Child's Name: _____ Date of Birth: _____ Enrollment Date: _____

I hereby acknowledge that I have received a copy of the *Parent Essentials Handbook*. I have reviewed and understand all of the Golden Star Learning Academy policies and regulations.

(Printed Name) (Signature) (Date)

Please place a check (✓) next to each item (<i>authorized or not authorized</i>)	<u>Authorized</u>	<u>Not Authorized</u>
1. My child may use a cot, blanket and pillow during rest time.	_____	_____
2. Staff may apply the following products to my child.		
Diaper Ointment	_____	_____
Diaper Wipes	_____	_____
Diaper Powder	_____	_____
Baby Lotion	_____	_____
Sun Block	_____	_____
Lip Balm	_____	_____
Other: _____	_____	_____
I understand that I must provide and clearly label/date these products.		
3. My child <u>may</u> be photographed during activities and field trips and his/her likeness used in marketing materials.	_____	_____
4. My child <u>may</u> participate in nature walks in the neighborhood.	_____	_____
5. My child <u>may</u> participate in outdoor water play activities.	_____	_____

I hereby authorize Golden Star Learning Academy® to release my child to the following persons (other than parents):

Name: _____	Relationship: _____
Address: _____	Telephone #: _____
Name: _____	Relationship: _____
Address: _____	Telephone #: _____
Name: _____	Relationship: _____
Address: _____	Telephone #: _____

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, in the event such an emergency occurs and I cannot be reached, I hereby authorize Golden Star Learning Academy® to provide for transportation of my child to _____ (Name of Hospital) (or the nearest hospital) and to secure for my child all necessary medical treatment. I understand that the teachers in the child care center are trained in the basics of first aid and I authorize them to provide my child with first aid when appropriate.

I hereby indemnify and hold harmless Golden Star Learning Academy® of _____ and its owners, agents and employees against any and all liability for any and all injuries to my child arising from or related to the items listed on this form for which I have provided my authorization.

Parent/Guardian Printed Name _____ Parent/Guardian Signature _____ Date _____

BI-ANNUAL UPDATES:

BEHAVIOR MANAGEMENT POLICY

Golden Star Learning Academy® has developed a detailed set of policies regarding children's behavior management and discipline. Every member of our staff is required to follow each policy when handling behavior issues. The goal of our program is to emphasize respect for self, respect for others and their work, and respect for materials located in our academy.

Using appropriate methods of discipline that incorporate behavior management enables the young child to learn self-control and gain an understanding of the types of conduct that are acceptable. Children become more independent and self-sufficient when they take responsibility for their own behaviors. Self-discipline, learned during the early childhood years, is necessary in order to become a productive member of our society.

Every Staff Member operates under the following policies:

- Psychological abuse, coercion, and physical abuse, or injurious treatment of children is not permissible under any circumstances.
- No corporal punishment, including spanking, hitting, shaking, squeezing, jerking, biting, kicking, will ever be used.
- No child shall be subjected to cruel or severe punishment or verbal abuse, including those that are shaming, frightening or humiliating.
- No child shall be denied food, toileting or rest privileges as punishments.
- No harsh or profane language or implied threats promising physical punishment shall be used.
- No child shall be punished for soiling or wetting him/herself or not using the toilet.
- No coercion when disciplining a child, such as rough handling (shoving, pulling, pushing, grasping of any body part); forcing a child to sit down, lie down, or stay down, except when restraint is necessary to protect the child or others from harm; physically forcing a child to perform an action (such as eating or cleaning up).

We recognize and praise appropriate and positive behaviors. A teacher's response to inappropriate or negative behaviors may include redirecting the child's activity, reasonably discussing the problem or using planned ignoring. The child may be directed to an area of the classroom to participate in an activity that is calming. This approach gives the child an opportunity to reflect on his/her actions. In the event that inappropriate behavior continues despite utilizing the above-stated techniques, the director will observe the child in the classroom and collaborate with the teachers, to assess the function of the behavior. Then, the director will set up a meeting with the child's parents, and the classroom staff, to develop an individualized program that meets the child's needs and is agreeable to all parties. The specific program will include positive behavior support strategies and is to be implemented within the classroom's daily programming. As needed, additional resources, professionals, and/or local agencies may be included to support the behavior management plan.

In the event that all possible interventions and strategies have been exhausted, exclusionary measures, such as suspension or expulsion, will be considered. Our goal is to limit exclusionary measures and will only be considered when the health and safety of the child, other children, or staff is jeopardized. Examples include but are not limited to violent behavior (kicking, punching, throwing), extreme biting, or threatening harm to others. Before a decision is made to suspend or expel a child, teachers and management will work together with families to resolve the behavior using all other positive behavior methods as stated in the policy. Exclusionary measures are not taken unless there is an agreement from all parties that it is in the best interest of the child. If exclusionary measures are taken the program will offer assistance to the family in accessing services and an alternative placement.

Name: _____

Date: _____

Signature: _____

Enrollment/Start Date: _____

PUBLICITY RELEASE AGREEMENT

Date: _____

I hereby consent to the use of my name, photograph or other likeness by Golden Star Learning Academy and/or its corporate affiliates, their respective employees, agents, licensees, and assigns in all marketing and advertising materials, publications, word of mouth programs, Web sites, social media and/or in media interviews without restriction as to manner, frequency or duration of usage.

I further agree that my name and/or photograph or other likeness may be used with whatever visuals, copy or other elements for Golden Star Learning Academy's online newsletters, Web sites, social media sites or in electronic/print media and I agree that all such materials produced hereunder are and will remain the sole and exclusive property of Golden Star Learning Academy and will not have to be reviewed with me prior to their use.

I further consent to the use of statements, comments, or opinions I have made, whether oral or written, referring or relating to Golden Star Learning Academy, and its businesses.

I hereby warrant and represent that the statements attributable to me, accurately reflect my true and honest belief and my actual experience with Golden Star Learning Academy, which I testify to and recommend. I agree to execute whatever documents Golden Star Learning Academy requires confirming this warranty and representation.

I represent that I am over the age required by law in this state to enter into binding agreements and that I have no conflicting contractual obligations that would interfere with my performing services hereunder or my granting the rights herein granted. If I am under age, the signature of my parent/guardian below shall constitute the parent/guardian's consent on my behalf to the terms and conditions of the Release Agreement. This consent is irrevocable and is given on the express understanding and condition that no reward or compensation is or shall be due to me or to the undersigned parent/guardian for the giving of this consent or for the grants and licenses provides herein.

I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof.

Signature: _____

Printed Name: _____

Address: _____

Telephone: _____

For Minors under 18 yrs of age:

Signature of Parent/ Guardian: _____

Print Name: _____

Print Child's Name: _____

FIRST DAY CHECKLIST

Child Name: _____

To ensure that we have all the items from home your child will need on a daily basis, please drop off the following items before the first day of enrollment. Please label all personal belongings. Some items will need to be taken home daily (to be washed and reused the next day) or weekly (to be laundered and brought back with you the following week):

Infants and Toddlers:

_____ Diapers
_____ Wipes
_____ Powders, ointment, sun screens, etc*
_____ Family photo

_____ Formula, bottles, food (Must be individual serving portion Labeled with child's first and last name and date)
_____ Change of Clothes
_____ Required Forms

Preschool and School Ages:

_____ Blanket
_____ Sheet, Pillow (optional)
_____ Change of Clothes
_____ Water Bottle

_____ Sunscreen* (No Spray)
_____ Diapers, and Wipes if applicable
_____ Family photo

(* require parent signature)

Forms:

Please reference parent essentials for explanation of each form that is required to be returned prior to your child's first day.

_____ Enrollment Agreement
_____ Admission Information (Form 2935)
_____ Child Assessment Form (Form 7293)
_____ Emergency Information
_____ Health Addendum
_____ Parent Authorization and Consent
_____ Behavior Management Policy
_____ Publicity Release Agreement
_____ Parent Essentials Receipt, First Day Checklist
_____ (Under 18 months) Infant Safe Sleep Policy for Parents and Guardians
_____ (Under 24 months) Infant/Toddler Schedule
_____ (if applicable) Diet Restriction Letter
_____ (if applicable) Transportation Plan
_____ (if applicable) Authorization for Dispensing Medication (Form 7238)
_____ (if applicable) Parental Custody Information

All Enrollees:

Once you have notified of acceptance for enrollment, please complete the admission process by taking the following steps:

- 1, Complete and submit all forms necessary for enrollment.
- 2, Submit your child's required proof of immunization and physical exam report form, completed and signed by a physician. Please note that, before your child can participate in any Academy activities, immunization requirements must be met in full. This for the health and safety of all children at the Academy.

parent essentials Receipt:

I have received a copy of the *parent essentials* handbook and the *Handbook Addendum* on _____
Date

I have reviewed and understand all of the Academy policies and procedures.

Parent/Guardian Signature

Date

Name (printed)

INFANT AND TODDLER SCHEDULE

(Updated every month)

Today's Date: _____ Date to be Updated: _____

Parents: Please provide general information about your child's routine.

Child's Name: _____ Child's Age (in months): _____ Arrival time: _____ Pick-up time: _____

Eating Times:

Foods / Formulas Given: _____ Bottles / Food heated or given cold: _____

I don't like to eat: _____ Amounts: _____

I'd like to try these new foods: _____

Known Allergies / Dietary Restrictions: _____

Feeding recommendations from pediatrician: _____

Sleeping Times:

_____ Routine (rocked, pacifier): _____

Elimination:

Color: _____ Consistency: _____ Powder / Creams: _____

Recommended times of changes: _____

Additional Information:

Form of discipline used at home: _____ Languages spoken in the home: _____

At home I like to: _____

At home I don't like to: _____

Recent changes in family routine or environment that may affect my child: _____

Are there any indications of developmental, vision, hearing or speech delays? Please specify: _____

Is there any information that will help us take better care of your child? _____

My primary caregiver(s) is/are:

Time:

1. _____
2. _____
3. _____

Parent Name (printed): _____ Parent Signature: _____ Date: _____

DIET RESTRICTION LETTER

Date: _____

To the Golden Star Learning Academy®

I, _____ request that my child, _____,
not eat the following foods while at Golden Star Learning Academy:

1. _____ 2. _____
3. _____ 4. _____

The reason for this diet restriction is (please check one):

- ☐ Personal Preference / Religious
☐ Allergy (a note from the Doctor is attached to this form)
☐ Other (Please explain) _____

The following substitutions may be provided to my child.

Signature: _____

Printed Name: _____

.....

Office Use Only

- ☐ Request added to Classroom and Kitchen Food Allergy Chart
☐ Photo taken and posted
☐ Request and documentation in child's file(s)

SCHOOL AGE TRANSPORTATION PLAN

Name of Child: _____ Date: _____
Elementary School: _____ Name of Parent: _____
School Phone Number: _____ Parent's Home Number: _____
Teacher's Name: _____ Parent's Cell Phone Number: _____
Room Number/Grade: _____ Parent's Work Number: _____

From Golden Star Learning Academy® to School:

Time school begins: _____ Time of departure from academy: _____
Indicate means of travel from academy to school: (circle one) School Bus **OR** Golden Star Learning
Academy Vehicle If child travels by school bus:
Name of company: _____ (Phone #) _____
Bus number / driver's name: _____ / _____

From School to Golden Star Learning Academy:

Time of dismissal from school: _____ Time of return to
academy: _____ Indicate means of travel from school to academy: (circle one) School
Bus **OR** Golden Star Learning Academy Vehicle . If the child travels by bus: (Please complete only if
different from above):
Name of bus company: _____ (Phone #) _____
Bus number / driver's name: _____ / _____

If the child walks to the academy, indicate route the child takes each day:

If traveling via public School Bus:

My child is to be released/received by Golden Star Learning Academy according to the plan outlined above. I understand that the academy and its employees are not liable or responsible for my child en route from the school to the academy.

Parent / Guardian Signature _____ Date _____

Director Signature _____ Date _____

If traveling via Golden Star Learning Academy Vehicle: I, _____
(Parent's Name) hereby provide the Golden Star Learning Academy permission to transport my child to
and from _____ (Name of School), Monday through Friday. In the event that a
special activity takes place after school, the parent will notify the academy in writing regarding the activity and the
revised time of pick up.

This form must be updated annually; the parent is responsible for informing the academy in writing of any changes to this plan.

Parent / Guardian Signature _____ Date _____

Director Signature _____ Date _____

Updated

Updated

Updated

Updated

Updated

Updated

ACH Automatic Draft Authorization Form

New Authorization: _____. Change to existing: _____. Cancellation of Authorization: _____.

Name of the Child:	
Account Owner Name:	

Draft frequency: Weekly_____, Bi Weekly_____, Monthly_____. Semimonthly on 1st and 15th _____.

Checking or Savings account Information

A voided check or bank documentation with routing number is required for drafts from checking or saving account.

Bank Name:	
Bank Phone Number:	
Bank Account Number:	
Bank Routing Number:	

Attached Voided Check Here

I hereby authorize Golden Star Learning Academy of _____ to draft the account indicated above to pay my monthly tuition and charges due for the Child/Children named above. I understand that my bank account will be drafted for the total amount due on the account due date at the frequency noted above.

- I understand that this automatic draft will remain in effect until the Golden Star learning Academy has received written notification of cancellation. In order to cancel this automatic draft, a written notice of 10 business days is required before the next draft date.
- This bank draft service may be terminated upon receipt of notification for insufficient funds or if declined or returned for any reason. I also understand if a draft is returned for insufficient funds declined, there will be \$39 service charge per the enrollment agreement.
- I understand that it is my responsibility to notify Kiddie Academy of any changes to my account number or expiration date.

Signature: _____. Date: _____.

Print Name: _____.

Office Use Only

Received Person Signature: _____. Received Date: _____.

Print Name: _____.