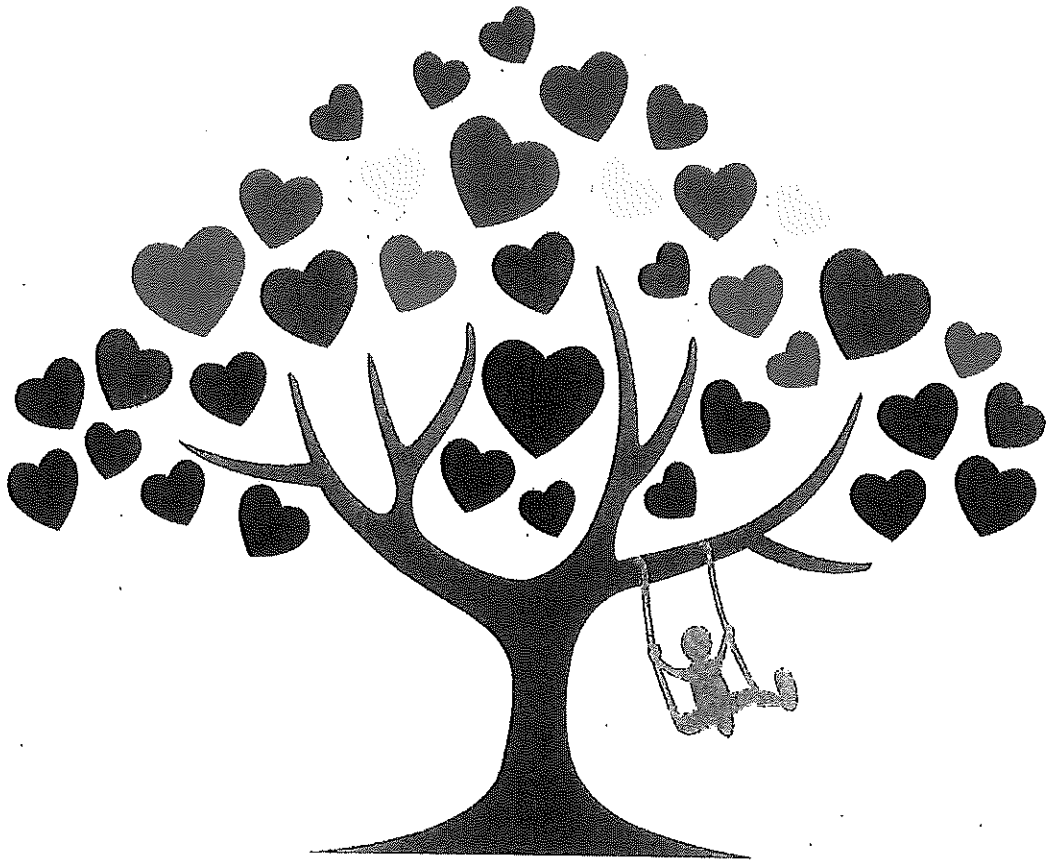


Promise Land

LEARNING CENTER

Registration Packet

Dear Parents,

Welcome to Promise Land Learning Center, a ministry of Living Branch Church. The foundation of our center is established on the belief in our Lord and Savior Jesus Christ and Him Crucified.

Our teachers have a love for the work they do and demonstrate that love through the daily activities provided. All of our staff receive a minimum of 24 hours of training per year. Training classes focus on child growth and development, guidance and discipline, age appropriate curriculum, teacher-child interaction, and much more. Our staff is certified in CPR and first aid.

We are grateful for the opportunity to teach your children. Our job is to have fun while learning with focus on the Fruit of the Spirit; Love, Joy, Peace, Patience, Kindness, Goodness, Faithfulness, Gentleness, and Self-control. (Galatians 5:22-23)

If you have any questions, concerns, or suggestions do not hesitate to speak with us. Our doors are always open to our parents.

Many Blessings and Welcome!
Cissy Musick, Director

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: Promise Land Learning Center	Director's Name: Mrs. Cissy Musick	
Child's Full Name:	Child's Date of Birth:	Child Lives With: ☐ Both parents ☐ Mom ☐ Dad ☐ 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: ☐ Yes ☐ 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:

☐ Discipline and guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medications
☐ Procedures for conducting health checks	☐ Immunization requirements for children
☐ Safe sleep	☐ Meals and food service practices
☐ Procedures for parents to discuss concerns with the director	☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to participate in operation activities	☐ 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/	☐ Pass ☐ Fail
Signature:	Date Signed:	

HEARING EXAM RESULTS

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ 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:

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:

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:

Promise Land

30 day infant schedule

Child's Name: _____

Breakfast Food: (Please circle) dry cereal w/ formula | #2 Fruit | #2 Cereal/ Fruit

Lunch Food: (Please circle) #2 Fruit | #2 Veggie | #2 Dinner | #3 Dinner

Pm Snack Food: Puffs

Bottle time:

Hours apart: _____ Amount: _____ Formula: _____

Tap water: _____ Bottle water: _____ Pacifier: Yes_____ No_____

Special Nap Instructions (Please NO Blankets):

_____

_____

_____

Other Special Instructions:

_____

_____

_____

Signature:_____ Date: _____

Signature:_____ Date: _____

Thank You!

OPERATIONAL POLICY ON INFANT SAFE SLEEP

Purpose: This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at Promise Land Learning Center

and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

SAFE SLEEP POLICY

All staff, substitute staff, and volunteers at Promise Land Learning Center

will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415 and §747.2315]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415 and §747.2315].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing

  (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415 and §747.2315].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must *not be attached* to a stuffed animal or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2415 and §747.2315].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2428 and §747.2328].

PRIVACY STATEMENT
DFPS values your privacy. For more information, read our privacy policy at: http://www.dfps.state.tx.us/policies/privacy.asp.

SIGNATURES	
This policy is effective on: _____ (date) Child's name:	
Signed by: X Director/Owner	Date signed:
Signed by: X Staff member	Date signed:
Signed by: X Parent	Date signed:

Form J-800-2710
New February 2017

INFANT-SLEEP EXCEPTION
HEALTH-CARE PROFESSIONAL RECOMMENDATION

Purpose: When a health-care professional determines that it is medically necessary for an infant to sleep in an alternative position (other than sleeping on the infant's back), sleep in a restrictive device (such as a bouncer seat or swing), or needs to be swaddled to sleep, use this form to ensure that a licensed child-care center, licensed child-care home, or registered child-care home that cares for the infant meets the minimum standards required by Texas Human Resources Code §42.042(e)(8). The standards for these operations require the operation to:

- follow the directions of an infant's health-care professional to provide specialized medical assistance to the infant; and
- maintain, while active, this form and any other directions from the health-care professional that the parent provides to the operation [See §746.603(a)(10) or §747.603(a)(9)]. Keep the exception form in the infant's classroom, so that a caregiver may refer to the health-care professional's instructions.

Directions: This exception will not be effective until all sections and signatures are complete. Once completed the exception is acceptable for use by the child-care operation.

INFANT'S INFORMATION		
Infant's Name:	Infant's Date of Birth:	Infant's Age:
Parent/Guardian's Name:		
Address:		
Home Phone:	Work Phone:	
Fax:	Email:	

The infant's health-care professional must complete the following section.

HEALTH-CARE PROFESSIONAL INFORMATION	
Name of Infant's Health-Care Professional:	
Name of Practice:	
Address:	
Phone:	Fax:
Email:	

The Texas child care minimum standards (§§746.2426, 746.2427 and 746.2428 for child-care centers or §§747.2326, 747.2327 and 747.2328 for licensed or registered child-care homes) require child-care operations to place all infants on their backs to sleep in a crib and to ensure that infants do not sleep in restrictive devices and are not laid down to sleep swaddled. But based on the advice of the infant's health-care professional, when medically necessary the center may be authorized to use an alternative-sleep position, restrictive device, or swaddle for the infant due to medical reasons.

The above-named infant has the following medical condition that necessitates an alternative-sleep position, allow for sleep in a restrictive device, or requires swaddling for sleeping:

HEALTH-CARE PROFESSIONAL INFORMATION

Please describe the appropriate sleep position/restrictive device/ swaddling technique to be used for the above-named infant and include the effective dates for the exception:

Effective Dates of Exception: **from** / / **to** / /

Health-Care Professional's Signature:	Date Signed:

WAIVER OF LIABILITY

- I affirm and acknowledge that the below-named child-care operation has provided me with the operation's safe sleep policy.
- I further authorize the child-care operation and its caregivers to place my infant in an alternative-sleep position, restrictive device, or swaddling at the recommendation of my infant's health-care professional, as described above.
- I, as the parent or guardian of the above mentioned infant, release and hold harmless the below-named child-care operation, its officers, directors, caregivers, and employees from any and all liability whatsoever associated with harm to my infant due to Sudden Infant Death Syndrome (SIDS).

Parent or Guardian's Signature:	Date Signed:

An authorized official with the child-care operation must complete the following section.

CHILD-CARE OPERATION INFORMATION AND SIGNATURE

Name of Child-Care Operation: Promise Land Learning Center	Operation Number: 401557
Operation Representative's Signature:	Date Signed:

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our privacy policy at:
http://www.dfps.state.tx.us/policies/privacy.asp.

Texas Dept of Family and Protective Services

Child Assessment Form

Form 7293
November 2012

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?	☐ Yes	☐ 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?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ 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?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ 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?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ 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?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

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?		☐ Yes	☐ 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)	

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:

Texas Department of
Family and Protective Services

Form J-800-1099
New January 2018

OPERATIONAL DISCIPLINE AND GUIDANCE POLICY

Purpose: This form provides the required information per minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

DISCIPLINE AND GUIDANCE POLICY

Discipline must be:

1) Individualized and consistent for each child;
2) Appropriate to the child's level of understanding; and
3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
2) Reminding a child of behavior expectations daily by using clear, positive statements;
3) Redirecting behavior using positive statements; and
4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

1) Corporal punishment or threats of corporal punishment;
2) Punishment associated with food, naps, or toilet training;
3) Pinching, shaking, or biting a child;
4) Hitting a child with a hand or instrument;
5) Putting anything in or on a child's mouth;
6) Humiliating, ridiculing, rejecting, or yelling at a child;
7) Subjecting a child to harsh, abusive, or profane language;
8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

ADDITIONAL DISCIPLINE AND GUIDANCE MEASURES (ONLY APPLIES TO BAP/SAP PROGRAMS THAT OPERATE UNDER CHAPTER 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

SIGNATURE	
This policy is effective on the following date:	
Signed by: X	Role: ☐ Parent ☐ Caregiver/Employee ☐ Household Member (Ch. 747 only)

MINIMUM STANDARDS RELATED TO DISCIPLINE

- Title 40, Chapter 746 Subchapter L:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=746&sch=L&rl=Y
- Title 40, Chapter 747 Subchapter L
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=747&sch=L&rl=Y
- Title 40, Chapter 744 Subchapter G:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=744&sch=G&rl=Y

Dear Families,

Thank you for choosing Promise Land for your child care needs. We are always looking for better ways to communicate with our families. One way we would like to expand is through pictures. We understand that your child has some very special moments while they are in our care and we would love to be able to photograph these moments for you. Some examples would be infants learning to crawl or walk; wobbler / toddlers climbing the slide, trying new foods and our class parties. With your permission we would take pictures of your child and post them in our center, send them to your email, post on our secured Facebook page when it is up and running or even post them on our web site page in activity pictures. As always no personal information will be given with the pictures. Below you will find the permission slip to allow us to photograph your child, please check the appropriate boxes, sign the permission and return it as soon as possible.

I _____ give P.L.L.C. permission to photograph my child

(PARENT'S NAME)

_____ during their time at P.L.L.C. Photo documentation

(CHILD'S NAME)

will be facilitated by P.L.L.C. staff members or affiliates. I understand that these photos may be used in the future by P.L.L.C. for promotional and/ or educational purposes.

I give ☐ I do not give ☐ permission for pictures of my child to be posted throughout P.L.L.C.

I give ☐ I do not give ☐ permission for pictures of my child to be emailed to me_____

I give ☐ I do not give ☐ permission for pictures of my child to be posted on P.L.L.C's secured Facebook page.

I give ☐ I do not give ☐ permission for pictures of my child to be posted on P.L.L.C's web site page in activity pictures

☐ I prefer not to have pictures taken of my child.

_____

(PARENT'S SIGNATURE)

Substitute Meals or Snacks

Here at Promise Land Learning Center we take great pride in serving a nutritional menu to our students. We understand that from time to time your child may want to bring a different meal and/or snack then what we are providing that day. By signing this form below, when you provide your child's meals and/or snacks you will not hold Promise Land Learning Center responsible for your child's nutritional value or meeting your child's daily food needs.

I _____ will always or on occasion bring my child's breakfast, lunch, and/or snacks. I do not hold Promise Land Learning Center responsible for my child's nutritional needs.

Print Name Sign Name Date

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) **Promise Land Learning Center** **to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ (*initial*) Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

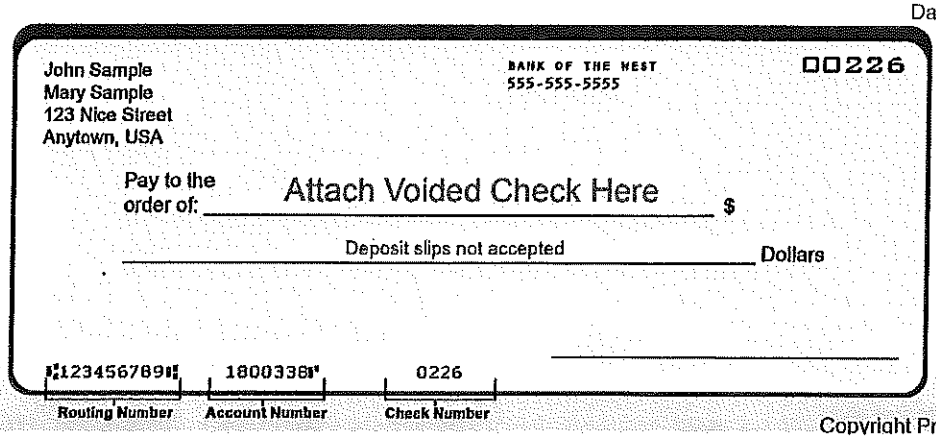
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of procare SOFTWARE®

Promise Land Learning Center

Child Care, Pre-K, & After School

"Behold Children are a Heritage from the Lord."

Dear Parents,

Thank you so much for your interest in our Promise Land Learning Center. Our staff is looking forward to getting to know you and your child(ren). Our responsibility of caring for child(ren) is one we take very seriously.

We like to partner with our parents in working together to meet the daily needs of the children. In order to do this, we ask for a commitment on the days you would like your child(ren) to attend.

Our policy at Promise land is that your child(ren) must be enrolled (2) days or more per week. If your child is reenrolled part-time and you occasionally need to change their days or add a day, you will need to call ahead to see if there is availability. If your child is going to be OUT FOR VACATION, please notify us (5) days prior. If your child is out sick, please notify us as to how long they might be out so we can pray for them and inform their teachers.

Your responsibility for payment are for the days you commit to, regardless if your child(ren) is out sick, on vacation or if we are closed. **Every Parent must fill out this form.**

Please fill out the bottom part of this form and return it to us. If the days change that your child(ren) are with us let us, please fill out a new form and return it.

Many Blessings,

Mrs. Cissy Musick (Director)

_____ **M – T – W – T – F**

Parent's Name Child's Name Start Date

Parents Emails: Mother _____ Father _____

13229 Highway 105 W * Conroe * Texas * 77304

Telephone (936) 588-3400 * Fax 588-3523 * Web Site plkids.org

Promise Land Learning Center

PRICE LIST FOR ALL CHILREN: Hours are 6:30am to 6pm - Pick up late fee is $1.00 per minute after 6:00pm

Operation times are: Monday – Friday year around- Holidays are posted & written in the parent handbook

Promise Land is at: 13229 Hwy 105 West * Conroe, Tx * 77304, **Phone:** 936-588-3400, Fax: 936-588-3523

Children's ANNUAL Registration Fee $50 (per family) Curriculum/Supply fee $50 (in August for Infants – 3yrs) NON-REFUNDABLE

INFANTS (3mon - 22mon)

	Weekly	Daily
Child (age 3mons to age 17mons)	$175.00 (This is a discount for full time)	$42.00
Child (age 18mons to age 23mons)	$170.00 (This is a discount for full time)	$42.00

Two yr olds – Three yr olds

	Weekly	Daily
2yr old classes	$155.00 (This is a discount for full time)	$42.00
3yr old classes	$155.00 (This is a discount for full time)	$42.00

PRESCHOOLERS (4yr olds) - PRE-KINDERGARTEN (4-5yr olds)

Preschoolers (4yrs) and Pre-K Fee's: Annual Registration $50/ Curriculum $150.00 (Discount before June 15th - $50.00)

4yr olds (Preschoolers)	$155.00 per week	$42.00
Pre-Kindergarten class (full day)	$155.00 per week (full week only)	(No part time fees)

SCHOOLERS- 5yr olds to 12yr olds BEFORE AND AFTERCARE

Before/After school care (M.I.S.D. only)	$75.00 per week	$15.00

Tuition is due every Monday and late payment fees of $25.00 are applied on Wednesday at noon.

SUMMER CAMP (4yr olds - 12yr olds)

Children Ages 4-12yrs Annual Registration Fee $50 (per family) Supply Fee $50 (per child) NON-REFUNDABLE

Child (age 4yrs)	$155.00 (full time) (including in house field trips ONLY)	$42.00
Child (age 5yrs – 12yrs)	$155.00 (fulltime) (including ALL field trips)	$42.00

There will be a $35.00 fee on all returned check

Please sign

Signature: _____ Date: _____

Promise Land Learning Center

13229 Hwy 105 W Conroe, Tx 77304

936-588-3400, fax: 936-588-3523, email: khiett@plkids.org

Doctor Release Form

Date: _____

Name of child: _____

Date of birth: _____

This child is free of any communicable diseases, up to date on their immunizations, and able to participate in daycare/ school.

Sincerely,

Address: _____

_____

_____

Phone: _____

Fax: _____

2018 - 2019 Texas Minimum State Vaccine Requirements for Child-Care and Pre-K Facilities

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This chart is not intended as a substitute for consulting the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Human Resources Code, Chapter 42.

A child shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a child-care facility or public or private elementary or secondary school in Texas.

Age at which child must have vaccines to be in compliance:	Minimum Number of Doses Required of Each Vaccine							
	DTaP	Polio	HepB	Hib	PCV	MMR	Varicella	HepA
0 through 2 months								
By 3 months	1 Dose	1 Dose	1 Dose	1 Dose	1 Dose			
By 5 months	2 Doses	2 Doses	2 Doses	2 Doses	2 Doses			
By 7 months	3 Doses	2 Doses	2 Doses	2 Doses[1]	3 Doses[2]			
By 16 months	3 Doses	2 Doses	2 Doses	3 Doses[1]	4 Doses[2]	1 Dose[3]	1 Dose[3]	
By 19 months	4 Doses	3 Doses	3 Doses	3 Doses[1]	4 Doses[2]	1 Dose[3]	1 Dose[3]	
By 25 months	4 Doses	3 Doses	3 Doses	3 Doses[1]	4 Doses[2]	1 Dose[3]	1 Dose[3]	1 Dose[3]
By 43 months, but before Kindergarten entry	4 Doses	3 Doses	3 Doses	3 Doses[1]	4 Doses[2]	1 Dose[3]	1 Dose[3]	2 Doses[3]

[1] A complete Hib series is two doses plus a booster dose on or after 12 months of age (three doses total). If a child receives the first dose of Hib vaccine at 12 - 14 months of age, only one additional dose is required (two doses total). Any child who has received a single dose of Hib vaccine on or after 15 - 59 months of age is in compliance with these specified vaccine requirements. Children 60 months of age and older are not required to receive Hib vaccine.

↓ Notes on the back page, please turn over.↓

Rev. 02/2018

[2] If the PCV series is started when a child is seven months of age or older or the child is delinquent in the series, then all four doses may not be required. Please reference the information below to assist with compliance:

- For children seven through 11 months of age, two doses are required.
- For children 12 - 23 months of age: if three doses have been received prior to 12 months of age, then an additional dose is required (total of four doses) on or after 12 months of age. If one or two doses were received prior to 12 months of age, then a total of three doses are required with at least one dose on or after 12 months of age. If zero doses have been received, then two doses are required with both doses on or after 12 months of age.
- Children 24 months through 59 months meet the requirement if they have at least three doses with one dose on or after 12 months of age, or two doses with both doses on or after 12 months of age, or one dose on or after 24 months of age. Otherwise, one additional dose is required. Children 60 months of age and older are not required to receive PCV vaccine.

[3] For MMR, Varicella, and Hepatitis A vaccines, the first dose must be given on or after the first birthday. Vaccine doses administered within 4 days before the first birthday will satisfy the requirement.

Information on exclusions from immunization requirements, provisional enrollment, and acceptable documentation of immunizations may be found in §97.62, §97.66, and §97.68 of the Texas Administrative Code, respectively.

Vaccines:

DTaP: Diphtheria, tetanus, and acellular pertussis (whooping cough); record may show DT or DTP
Polio: IPV - inactivated polio vaccine; OPV – oral polio vaccine
HepB: Hepatitis B vaccine
Hib: Haemophilus influenzae type b vaccine
PCV or PCV13: Pneumococcal conjugate vaccine
MMR: Measles, mumps, and rubella vaccines combined
Varicella: Chickenpox vaccine. May be written VAR on record.
HepA: Hepatitis A vaccine

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services • Immunization Unit • MC-1946 • P. O. Box 149347 • Austin, TX 78714-9347 • (800) 252-9152

Stock No. 6-15

Rev. 02/2018

Requisitos mínimos de vacunas en el estado de Texas de 2018 - 2019 para las guarderías y centros de pre-kinder

Esta gráfica resume los requisitos para vacunas incorporados al Código Administrativo de Texas (TAC), título 25, Servicios de salud, secciones 97.61 a 97.72. Esta gráfica no tiene como propósito sustituir las consultas al TAC, el cual contempla otras disposiciones y detalles. El Código de Recursos Humanos, capítulo 42, confiere al Departamento Estatal de Servicios de Salud (DSHS) la autoridad para establecer los requisitos de inmunización.

Los niños deberán mostrar comprobantes de vacunación aceptables antes de inscribirse, asistir o ser transferidos a una guardería o una escuela primaria o secundaria pública o privada de Texas

Edad a la que el niño debe recibir las vacunas para cumplir con los requisitos:	**Número mínimo de dosis requeridas de cada vacuna**							
	DTaP	**Polio**	**HepB**	**Hib**	**PCV**	**MMR**	**Varicella**	**HepA**
De 0 a 2 meses								
Antes de los 3 meses	1 dosis	1 dosis	1 dosis	1 dosis	1 dosis			
Antes de los 5 meses	2 dosis	2 dosis	2 dosis	2 dosis	2 dosis			
Antes de los 7 meses	3 dosis	2 dosis	2 dosis	2 dosis[1]	3 dosis[2]			
Antes de los 16 meses	3 dosis	2 dosis	2 dosis	3 dosis[1]	4 dosis[2]	1 dosis[3]	1 dosis[3]	
Antes de los 19 meses	4 dosis	3 dosis	3 dosis	3 dosis[1]	4 dosis[2]	1 dosis[3]	1 dosis[3]	
Antes de los 25 meses	4 dosis	3 dosis	3 dosis	3 dosis[1]	4 dosis[2]	1 dosis[3]	1 dosis[3]	1 dosis[3]
Antes de los 43 meses, pero antes de la entrada a kinder	4 dosis	3 dosis	3 dosis	3 dosis[1]	4 dosis[2]	1 dosis[3]	1 dosis[3]	2 dosis[3]

[1] Una serie completa de la vacuna Hib consta de dos dosis más una dosis de refuerzo a los 12 meses de edad o después (tres dosis en total). Si un niño recibe la primera dosis de la vacuna Hib entre los 12 y los 14 meses de edad, se requiere solo una dosis adicional (dos dosis en total). Si un niño ha recibido una sola dosis de la vacuna Hib entre o después de los 15 y los 59 meses de edad, cumple con los requisitos de esta vacuna específica. Los niños de 60 meses de edad o mayores no requieren recibir la vacuna Hib.

↓ Notas al reverso, por favor dé la vuelta. ↓

Rev. 02/2018

[2] Si la serie de vacunas PCV se empieza a administrar cuando el niño tiene siete meses de edad o más, o si el niño está atrasado con alguna dosis de la serie, entonces puede que no sean necesarias las cuatro dosis. Por favor refiérase a la información siguiente para ayudarse a cumplir con los requisitos:

- Para los niños de siete a 11 meses de edad, se requieren dos dosis.
- Para los niños de 12 a 23 meses de edad: si han recibido tres dosis antes de los 12 meses de edad, entonces requieren una dosis adicional (para un total de cuatro dosis) a los 12 meses de edad o después. Si recibieron una o dos dosis antes de los 12 meses de edad, entonces requieren un total de tres dosis, y al menos una de las dosis deberán recibirla a los 12 meses de edad o después. Si no han recibido ninguna dosis, entonces requieren dos dosis y ambas deberán recibirlas a los 12 meses de edad o después.
- Los niños de entre 24 meses y 59 meses de edad cumplen con los requisitos si recibieron al menos tres dosis, y una de las cuales la recibieron a los 12 meses de edad o después; o dos dosis, ambas recibidas a los 12 meses de edad o después; o una dosis recibida a los 24 meses de edad o después. De lo contrario, es necesaria una dosis adicional. Los niños de 60 meses de edad o mayores no necesitan recibir la vacuna PCV.

[3] Para la vacuna MMR y las vacunas contra la varicela y contra la hepatitis A, la primera dosis debe administrarse en o después del primer cumpleaños. Las dosis de vacunas administradas dentro de los 4 días anteriores al primer cumpleaños satisfacen los requisitos.

La información sobre las exclusiones de los requisitos de inmunización, la inscripción provisional y la documentación aceptable de las inmunizaciones puede encontrase en las secciones 97.62, 97.66 y 97.68, respectivamente, del Código Administrativo de Texas.

Las vacunas:

DTaP: Difteria, tétanos y tosferina acelular (pertussis); en el registro pueden aparecer como DT o DTP
Polio: IPV - vacuna inactivada contra la poliomielitis (polio); OPV - vacuna oral contra la poliomielitis
HepB: Vacuna contra la hepatitis B
Hib: Vacuna contra *Haemophilus influenzae* tipo b
PCV o PCV13: Vacuna antineumocócica conjugada
MMR: Vacuna combinada contra el sarampión, las paperas y la rubeola
Varicella: Vacuna contra la varicela. En el registro puede aparecer escrita como VAR.
HepA: Vacuna contra la hepatitis A

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services • Immunization Unit • MC-1946 • P. O. Box 149347 • Austin, TX 78714-9347 • (800) 252-9152

Stock No. 6-15

Rev. 02/2018

NEW ☐ UPDATE ☐ DROP IN ☐

Institution Name: CHILD CARE PLUS Agreement Number: CE ID 02051

Facility/Provider Name: Promise Land Day Care Center 1327

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date — Birth - 5 months	Today's Date — 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimubursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date — 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC Information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped:

Work Telephone Number: _____ Emergency Telephone Number: _____ _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no case number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _ _ _ _ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

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

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income:_____ **Per:** ☐ **Week,** ☐ **Every 2 Weeks,** ☐ **Twice A Month,** ☐ **Month,** ☐ **Year** **Household size:** _____

Categorical Eligibility:____ **Date Withdrawn:** _____ **Eligibility: Free**____ **Reduced**____ **Denied**____ **Tier I**____ **Tier II**____

Reason:_____

Determining Official's Signature: _____ **Date:** _____

Confirming Official's Signature: _____ **Date:** _____

Follow-up Official's Signature: _____ **Date:** _____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
This institution is an equal opportunity provider.

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

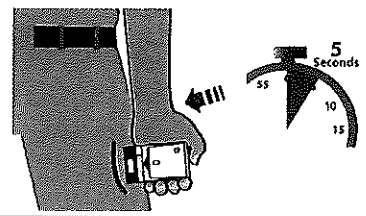
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

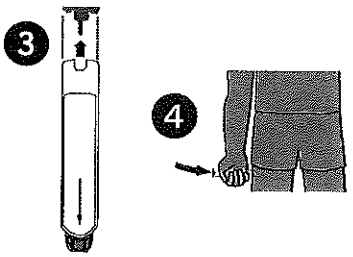
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



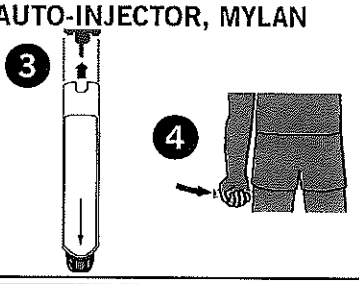
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



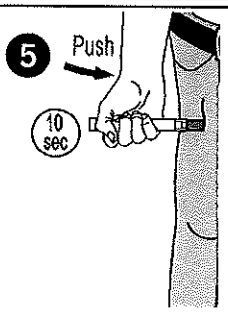
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

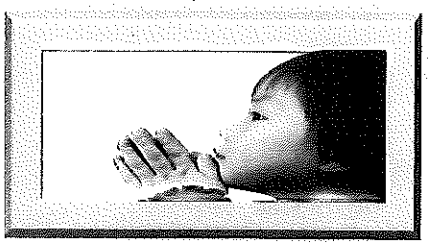
PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

Scriptures for Children



PROVERBS 22:6 – Train up a child in the way he should go, and when he is old he will not depart from it.

PSALMS 127:3-4 – Lo, children are a heritage from the Lord, the fruit of the womb a reward. As arrows are in the hand of a warrior, we are the children of one's youth.

ISAIAH 59:21 – As for me, says the Lord, this is my covenant with them:" My Spirit who is upon you, and My words which I have put in your mouth, shall not depart from your mouth, nor from the mouth of your descendants, nor from the mouth of your descendant's descendants", says the Lord, from this time and forevermore.

ISAIAH 54:13 – All your children shall be taught by the Lord and great shall be the peace of your children.

PROVERBS 23:24 – (Amplified) The father of the righteous (in upright standing with God) shall greatly rejoice, and he who becomes the father of a wise child shall have joy in him.

MATTHEW 18:4-5 – (Amplified) Whoever will humble himself therefore and become like this little child (trusting, loving, and forgiving) is greatest in the kingdom of heaven. And whoever receives and accepts and welcomes one little child like this for My sake and in My name receives and accepts and welcomes Me.

ISAIAH 11:8-9 – (Amplified) And the sucking child shall play over the hole of the asp, and the weaned child shall put his hand on the adder's den. They shall not hurt or destroy in all My holy mountain, for the earth shall be full of the knowledge of the Lord as the waters cover the sea.

JEREMIAH 29:11-13 – (Amplified) For I know the thoughts and plans that I have for you, says the Lord, thoughts and plans for welfare and peace and not for evil, to give you hope in your final outcome. Then you will call upon Me, and you will come and pray to Me, and I will hear and heed you.