THE LEARNING VOYAGE ENROLLMENT FORM

Entrance Date _____ **Withdrawal Date** _____

Child's Name Sex Age Date of birth

Home Address (Street)

City State Zip

Home Phone Number

Father's Name Home Phone Number

Father's Home Address (if different from child's) Street

City State Zip

Father's Place of Employment Work Phone

Employer's Street Address City State Zip

Mother's Name Home Phone Number

Mother's Home Address (if different from child's) Street

City State Zip

Mother's Place of Employment Work Phone #

Employer's Street Address_____City_____ __ ___State_____Zip__ _____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

The child may be released to the person(s) signing this agreement or to the following:

*Name Address

(Street-City-State-Zip)

Telephone Number _____ Relationship to child _____

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

*Name Address

(Street-City-State-Zip)

Telephone Number Relationship to child

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name

Doctor/clinic phone #

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth _____ suffer an injury or illness while in the care of (Facility name) _____

and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: _____

Signature

Date: _____

Facility Administrator/Person-In-Charge _____

Signature

Date:

Parental Agreements with Child Care Facility

The _____ agrees to provide child
care for (Name of Facility)

_____ on _____ _____ a.m. to _____ p.m. (Name of Child)

from _____ to
_____.

(Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast

Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for

_____.
(Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date:
_____ (Parent/Guardian)

Signed: _____ Date:
_____ (Facility Administrator/Person-In-Charge)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

_____ _ Parent/Guardian Signature

Date

Parents or Guardian's

Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, _____, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____

Parents or Guardian's Signatures **Date**

_____ **Parent or Guardian (Print Names)**

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if _____

Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

Name:_____
D.O.B.:_____

PLACE PICTURE HERE

Allergic to:_____

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

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

Extremely reactive to the following allergens:_____

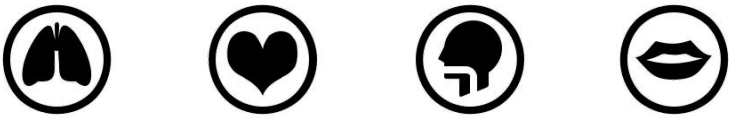
THEREFORE:

☐ 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

OR A

SKIN
Many hives over body, widespread Redness

GUT
Repetitive vomiting, severe diarrhea

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

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	MOUTH	SKIN	GUT
Itchy or runny nose, sneezing	Itchy mouth	A few hives, mild itch	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: _____ ☐

☐ ☐

Antihistamine Brand or Generic:_ _____

Antihistamine Dose:_____

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

_____

PARENT/GUARDIAN HEREBY ACKNOWLEDGES AND AGREES TO THE FOLLOWING:

Medical Attention: I hereby authorize any licensed physician or medical facility to treat my child in the event of an emergency and in the event parent/guardian cannot be reached and will hold The Learning Voyage (TLV) harmless in the event of such an emergency. I give my permission to the medical personnel selected by TLV to secure emergency medical treatment, including, but not limited to, first aid, CPR, admission to any hospital, tests, surgery or general anesthesia, so long as care is provided by persons or facilities licensed in the state in which such treatment is rendered.. I further acknowledge that any medical treatment ordered is my financial responsibility and not that of TLV, or any of its agents, employees or volunteers. _____ (Initial)

External Childcare: TLV strongly discourages its staff from providing any child care services that are not a part of the child care program offered by TLV to our customers. While we cannot prohibit our staff from engaging in such outside activities, we want you to understand that if such outside services are performed for you or on your behalf by a TLV staff member, TLVshall NOT be held responsible for any acts or omissions of a TLV staff member while providing such services to you. Staff members are prohibited from exchanging personal cell and home numbers with parents. _____ (Initial)

Photography: With intent to be legally bound, I give permission to TLV to photograph my son/daughter (photo's will be used for students portfolio) and use the resulting photographs for any purpose VOLC deems proper, including school website & social media, in accordance to the law and I relinquish all rights, title and interest in finished photographs and negatives. _____ (Initial)

Tuition and Fees: All fees and tuition for childcare will be paid on Friday, for the upcoming week. I understand that if fees and tuition for child care are not paid for by Monday, an initial late charge of $35.00 will automatically be charged to my account. Should the fee become delinquent by one (1) week, immediate withdrawal of my child will be required. Further, if payment is returned for insufficient funds or a stop payment is made, I will be charged $50.00. The undersigned acknowledges that the entire overdue balance is a legal debt; that said debt is due and owing on Friday mornings by 9:00 a.m. for the coming week; and that TLV reserves the right to file legal proceedings and to request costs and attorney's fees in connection with collecting this debt. _____

(Initial)

Nonpayment is considered theft of services. TLV aggressively pursue collection of debts through appropriate legal action. Parents are responsible for full tuition after the date of the letter of withdrawal (must provide a two week notice), I understand that registration is a non-refundable fee. An annual fee of $50 is due by the First Friday in January for every school year. The fee is due for each child registered. If the fee is not paid there will be an automatic withdrawal. Further, if my child is withdrawn without two weeks' notice, I acknowledge that a penalty

fee will be assessed equivalent to one week of tuition. _____ (Initial)

Absentee Policy: I understand that if my child is absent, I will be held responsible for full tuition (100%) of my weekly fee. I understand 0-5 days is full tuition. Exceptions may be made due to illness with a doctor's note, final decision will be made at the directors/owners discretion. I understand that no credit for tuition will be given when TLV is closed due to severe weather conditions, Emergencies or holidays. _____ (Initial)

Late Pick-Up Fees: I understand that there is a $1.00 per minute/per child fee at 5:01 p.m. I further understand that after the third (3rd) late pick-up, there will be a $3.00 per minute/per child fee. I understand that the fee must be paid upon pick-up, not to exceed the next tuition payment. _____ (Initial)

Uniforms: I understand that TLVis a uniformed school (ages 2-5) which consists of red or black logo polo style shirt and Khaki bottoms. All polo shirts must have theTLV logo.. Students are exempt from wearing uniforms on Fridays and specified Holiday weeks.

_____ (Initial)

Breakfast/Lunch/Snacks: I understand that breakfast is served from 6:45 a.m. to 7:45 a.m., a hot lunch from11a.m. to 12 p.m. and an afternoon snack 2:30p.m. to 3:30p.m. I understand that if my child is not at TLV Center by the time breakfast is served, he/she should be fed prior to coming inside of the school. Please **do not** send your child into the classroom with outside food, as this may affects the learning environment. _____

(Initial)

Arrival Time: I understand that my child should be at TLV at least by 9:00 a.m. If my child is not at school by 9:00 a.m. you must call TLV to inform us of tardiness or absence. Doctors note is required upon return (If my child receives immunization shots, he/she must remain absent for 24 hours). _____ (Initial)

Medication: I understand that TLV does not give medication to any student for any reason at all. If my child has an asthma pump (albuterol) or an EpiPen, it may be left in the front office with a school administrator, accompanied by a doctor's note. _____ (Initial)

Sick Policy: I understand that TLV cannot permit children with communicable diseases to attend or remain in school. A child with a fever over 100 degrees, diarrhea, vomiting or nausea must not attend or remain in school. I understand that if my child is ill, including, but not limited to a severe cough or sore throat; undetermined rash or spots; boils; congestion; runny nose with green or yellow mucus; pink eye; head lice; and severe headaches, he/she cannot be accepted into the school until symptoms have been absent for 24 hours. I understand that in the case that I am called, I agree that my child will be picked up within one (1) hour. _____ (Initial)

School Closings: TLV closes when there is inclement weather reported for Barrow schools/ Government; I understand thatTLV will be closed the full day (unless otherwise noted) on the following dates and that **no discounts, credits or deductions are given for school closings.** _____ (Initial)

Labor Day	Thanksgiving Eve (closes at noon)	Thanksgiving Day	The day after Thanksgiving	Christmas Eve	Christmas Day	The day after Christmas	New Year's Eve (closes at noon)
New Year's Day	Martin Luther King, Jr.'s Birthday	President's Day	Memorial	Independence DayDay(Observed on the 3rd)	Teacher planning	And….	All other days on our calendar

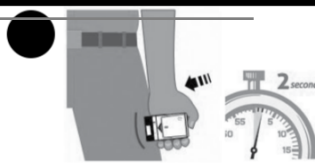
ACKNOWLEDGEMENT OF POLICIES & GUIDELINES: By signing below, I acknowledge that I have read the above information, and I understand the policies and guidelines of the program and I agree to abide by them. Should I have any questions or concerns, I will contact the Director. I understand that the staff makes every effort to provide a quality program, but additionally it is important that participants and parents follow all rules, guidelines and procedures in order for the program to be a successful experience for all.

I also acknowledge that I have received a Parent Handbook.(via email)

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

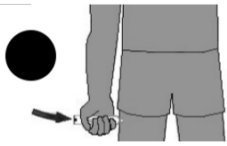
SIGNATURE OF TLV staff:_____ DATE: _____

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

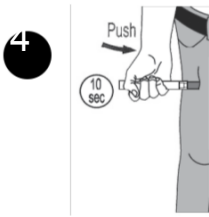


1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN 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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



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

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

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Safe Sleep Practices Policy

Child's name:_____ Date of birth:_____

Parent/Guardian name:_____

Safe Sleep Practices/Policies:

□ Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

□ Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

□ No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

□ No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

□ Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

□ Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

_____

□ Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

□ Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

□ Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

INFANT FEEDING PLAN

Child's Full Name _____ Date _____

Date of Birth _____

Does the child take a bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (check all that apply)

Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used, if applicable?_____

Amount and time of formula/breast milk to be given?_____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: _____

The child has reached the following developmental skills:

Can hold his/her head steady? Yes [ ] No [ ]
Opens mouth/leans forward in anticipation of food offered? Yes [ ] No [ ]
Closes lips around a spoon? Yes [ ] No [ ]
Transfers food from front of the tongue to the back and swallows? Yes [ ] No [ ]

Instructions for the introduction of solid foods

_____

_____

Food likes _____
Food dislikes _____
Allergies? (including any premixed formula)_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_ **PARENT'S SIGNATURE:** _____ Date: _____