



CHILD REGISTRATION FORM

CHILD'S INFORMATION:

Last Name _____ First Name _____ Gender: M/F

Date of Birth _____ Age _____ Enrollment Date _____ Start Date _____

Assigned Classroom _____ Days Attending (*please circle*) M T W Th F

School Meal Plan: Yes/No ___ Non-Vegetarian ___ Vegetarian Pizza Fridays: Yes/No Parent View: Yes/No

Allergies or other important information: _____

I give permission for my child's photo to be sent via the Tadpoles system. Initials _____

For security purposes, please provide both parent/legal guardian information

PARENT/LEGAL GUARDIAN 1 INFORMATION:

Last Name _____ First Name _____ Gender: M/F

Home Address _____ City _____ State _____ Zip Code _____

Social Security Number ___ - ___ - ___

Employer _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

PARENT/LEGAL GUARDIAN 2 INFORMATION:

Last Name _____ First Name _____ Gender: M/F

Home Address _____ City _____ State _____ Zip Code _____

Social Security Number ___ - ___ - ___

Employer _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____



CUSTODIAL ACKNOWLEDGEMENT:

I understand that providing both parents/guardians information gives both parties the right to visit/pick up the above mentioned child at any time. If custody circumstances change for any reason, Lightbridge Academy must be notified in writing and we may request documentation by the proper authority.

Parent 1 Signature _____ Parent 2 Signature _____

CUSTODIAL INFORMATION:

If a non-custodial parent is not among those persons authorized to pick up the child or if a court order pertains to your custodial agreement, a court order must be provided. Please check the appropriate box below.

____ Yes, this situation applies. A court order is attached.

____ Not Applicable

EMERGENCY CARE AUTHORIZATION:

In the event that a medical emergency occurs, I authorize Lightbridge Academy to perform first aid and/or seek emergency care for my child as deemed necessary by the Director and I authorize such medical provider to carry out required emergency treatment.

Signature: _____ Date: _____

MARKETING INFORMATION:

How did you hear about Lightbridge Academy?

____ Personal Referral (If so, who?) _____

____ Drive-By

____ Internet (what search engine?) _____

____ Advertisement (which one) _____

I understand and agree to the policies and requirements outlined in the Lightbridge Academy Handbook and the Financial Agreement. Specifically, I understand that full tuition is due regardless of holidays, snow days, short-term illnesses, or vacations. All returned transactions will be assessed a penalty to cover banking fees. In addition, I understand the Expulsion Policy and Parent Code of Conduct (included in the Parent Handbook).

Parent/Legal Guardian 1 Signature: _____ **Date:** _____

Parent/Legal Guardian 2 Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE CONSENT

Administration of First Aid Procedures/Obtaining Emergency Medical Care: _____

Emergency Transportation by the Facility: _____

Walks (in the event of an Evacuation): _____



CHILD HEALTH REPORT
(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		WORK PHONE:
FACILITY PHONE:	COUNTY:	
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">VISION (subjective until age 3)</td> <td style="width:40%;"></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S AS SISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

CD 51 09/08



EMERGENCY CONTACT INFORMATION FORM

(For Office & Classroom Emergency Binder)

Child's Name: _____

Child's Address: _____

Birth date: _____ Days per Week _____ (M T W Th F) (FT) (PT am pm)

Parent 1 Information:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Parent 2 Information:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Health Insurance Company:

Policy Number

Child's Allergy Information

Please list all allergies and any important information we need to know about your child including food he/she is NOT ALLOWED to have.

Emergency Contacts/ Authorized Pick – Ups

1. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone _____

2. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone: _____

3. Name: _____ Relation to Child: _____

Address _____

Work Phone: _____ Cell Phone: _____

In the event of a minor injury (cut, scrape, etc) would you like to be notified? _____

Which parent should we contact first in case of an emergency? _____



(Second page of Emergency Contact Form)

Child's Name _____

Dietary preferences _____

If cakes, cookies, or other treats are given as a snack in the event of a Birthday or other special occasion, may your child participate? Please circle Yes or No

Is a language other English spoken at home? _____ If so, what language? _____

What Holidays do you and your family celebrate?

- | | | |
|---------------------|-----------------------|------------------------|
| _____ New year's | _____ Valentine's day | _____ St Patrick's Day |
| _____ Easter | _____ Cinco de Mayo | _____ Independence Day |
| _____ Rosh Hashanah | _____ Ramadan | _____ Halloween |
| _____ Thanksgiving | _____ Chanukah | _____ Christmas |
| _____ Kwanzaa | _____ Diwali | |

Other(s): _____

I, the parent or guardian;			
<input type="checkbox"/> Received complete written program information/current tuition sheet and the financial agreement at the time of enrollment.			
<input type="checkbox"/> Agree to update the emergency contact/parental consent information whenever changes occur or every 6 months a minimum.			
_____		_____	
Signature – parent/guardian		date	
Periodic Review			
_____		_____	
Signature – parent/guardian		Signature – parent/guardian	
date		date	
_____		_____	
Signature – parent/guardian		Signature – parent/guardian	
date		date	

PARENT/GUARDIAN SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE CONSENT

Administration of First Aid Procedures/Obtaining Emergency Medical Care: _____
Emergency Transportation by the Facility: _____
Walks (in the event of an Evacuation): _____



AUTOMATED ELECTRONIC FUNDS TRANSFER
AUTHORIZATION FORM

Center: _____ Center's Employer Identification Number: _____

Child's Name: _____

TAPE VOIDED CHECK HERE

I/We _____ hereby authorize Lightbridge Academy® Child Care Centers to initiate debit entries (and if necessary, credit adjustments for any debit entries in error due) to my/our __checking __savings account (select one) from the depository listed below. I understand that the amount of the funds transferred from my account to Lightbridge Academy® will occur on the 27th of the month proceeding the month services are rendered or if the 27th falls on a holiday or weekend the EFT will occur the last Lightbridge Academy® business day preceding the 27th. I understand that the amount withdrawn each month from my account will equal the amount of the outstanding balance owed on my account. I also understand that a \$40.00 fee will be charged to me on all electronic payments dishonored.

Depository Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Transit /ABA#: _____ Account #: _____

This authority is to remain in full force and effect until Lightbridge Academy® has received written notification from me/us of its termination in such a manner as to afford Lightbridge Academy® a reasonable opportunity to act on it (minimum of seven business days).

Name (s) on account: _____

Signature: _____ Date: _____

Signature: _____ Date: _____



FINANCIAL AGREEMENT

This agreement is made and entered into between Lightbridge Academy® Child Care Centers and
(Parent(s) _____ Name)

_____ The
Center hereby accepts (Child's Name) _____ for
enrollment beginning _____, 20___. I/We the parent(s), agree to pay the applicable
tuition and fees for the services which we subscribe per month under the following terms:

1. Yearly tuition is divided into equal monthly payments. Adjustments or pro-rated tuitions are not applicable for illness, vacations, and closings due to holidays, inclement weather or as a result of the end of the programs cycle. All monies, once paid are non-refundable. Once you have paid your child's tuition for the month, you are committed for the entire month. There is no exception to this policy. Any change in tuition becomes effective as of the 1st of the next month. This refers to a child moving from one program to the next or a shift in the number of days a child is scheduled to attend in the program in which they currently participate.

2. Any child registered who does not start at the Center on the agreed upon date will forfeit all deposits and fees paid (unless previously agreed to with the Center Director).

3. An annual registration fee (non-refundable) and a one-time only security deposit are due at the time of enrollment to guarantee space for your child. The security deposit will be held in a noninterest bearing account and will be applied to delinquent tuition payments if necessary. If in the event this security deposit is used for the above stated purpose it must be replaced before your child can return to school. The security deposit will be applied to the last month's tuition as a credit when your child leaves Lightbridge Academy®. Security deposits will not be credited unless Lightbridge Academy® is notified (in writing) at least 45 days prior to terminating services. The security deposit will be credited to the final two weeks of the last months services provided.

4. It is the responsibility of the parent to maintain tuition payments throughout any intermission in attendance, regardless of the length of time, to continue your account in good standing. Interruption of payments resulting from temporary withdrawal from the center will result in the forfeiture of the Registration Fee and Security Deposit and risk losing the child's space. If space is available upon return, a new Registration Fee and Security Deposit will be required prior to reinstatement and is subject to all previous conditions.

5. Monthly tuition payments are due on the 27th of the month preceding the month of service and will be automatically deducted using the automatic EFT (Electronic Funds Transfer) system. If this date falls on a weekend or a holiday, payments will be due the last Lightbridge Academy® business day prior to the due date. Payments received after the due date will be subject to a \$40.00 "Late Fee" for each day they are late. Payments not received by the 1st of the month will result in the interruption of the child's attendance until all financial obligations including late fees are up to date.



6. If you terminate services and have an outstanding balance due on your account, you will be held responsible for paying your bill. If it is necessary that we must seek legal action against you in order to obtain payments due, you will be responsible for all of our collection and legal costs including attorney and court fees.

7. There will be a \$40.00 fee charged for any returned checks or accounts accessed which do not have sufficient funds to cover tuition payments.

8. A late pick-up fee will be imposed for children held after their scheduled pick-up time. This charge will be assessed at a rate of \$10.00 for each ten-minute period, or portion thereof beyond the scheduled pick-up time. This fee will be charged even if you have notified us that you will be late. The late pick-up fee will be billed to you on the following day and must be paid within two business days. We will use the clock located in the office to determine if a parent is late. Please set your watch to this time. Try to make alternate arrangements if you cannot be at the Center in time to pick up your child. This will save you a late fee and ensure our staff a timely departure. Chronic lateness is not acceptable, regardless of fees and could result in termination of services and forfeiture of your Security Deposit.

9. In the event your child has not been picked up by 7:30 p.m. and we have not been in contact with you or the emergency contact, we will by law call DHS. See Policy on the Release of Children.

I/We have read the above terms and understand the financial commitment to Lightbridge Academy®. I/We recognize that this is a legal agreement. I/We sign it with the full knowledge and consent of its meaning and importance.

Signature of Parent /Legal Guardian	Relationship	Date
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Signature of Parent /Legal Guardian	Relationship	Date
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Child's Name		
Program/ days 2 3 5	Tuition Fee	Payment schedule
Service Hours		Discount or Promotion
Additional Services and Rates:		
Signature of Director/Operator	Date	Signature of Parent/Guardian
		Date



IDENTIFICATION FORM

Child's Name: _____

Parent's Signature: _____

Please bring in copies of identification (i.e. drivers license) on or before your child's first day at Lightbridge Academy®.

Please attach:

Parent /Legal Guardian 1's License:

Parent /Legal Guardian 2's License:



MEDICATION ADMINISTRATION PACKET

Dear Parents,

This packet contains a Medication Administration Policy as well as other policies to help us provide the best possible care for your child. They include: Diaper Cream Permission, Sunscreen & Insect Repellent Permission, Medication Authorization Form,

These policies are in accordance with the most up to date state and federal regulations. Please take the time to read through below on the new uses and guidelines of these forms.

1. Medication Administration Policy-Please read through, sign and return to the center.
2. Medication Authorization Form. Our suggestion is to keep this in the glove box of your car so that any time you are taking your child to the doctor you will have it on hand. **No medication will be administered without these forms completed by both a parent and health care provider.**
3. Permission for Sunscreen and Insect Repellent
4. Authorization for Diaper Cream and Topical Lotions
5. Care Plan for Children with Special Health Needs-This form needs to be completed by the health care provider in the event a child has any special health needs including asthma or allergies. This form should be updated in the event of a change of how the health need will be treated or every August, whichever comes first. Please see your Director if your child requires this form.
6. Food Allergy Action Plan & Asthma Action Plans-These should be completed by both the health care provider and the parent/guardian. These should be updated when there is a change in treatment or every August. Please see your Director if your child requires this form.

What to do now:

- Carefully read through the Medication Administration Policy.
- Discuss any questions with the center Director.
- Sign and return the Medication Administration Policy.
- If your child suffers from any food allergies or asthma, have your health care provider complete the appropriate action plans and promptly return them to the center.
- If your child is currently in need of diaper rash lotions or other topical lotions, have your health care provider complete the authorization record and promptly return to the center.

What to prepare for:

- Keep copies of Medication Authorization Form and Topical Lotion Authorization Form in your car. They will be on hand for when you visit your child's health care provider. These forms must be completed by a health care provider before any medication is administered at the Center.
- We are required to maintain yearly updates to these records. These forms will be updated every August.

All forms must be returned to the office upon registration. As always, please feel free to stop in the office if you have any questions.



MEDICATION ADMINISTRATION POLICY

PURPOSE: This policy was written to encourage communication between the parent, the child's health care provider and the child care provider to assure maximum safety in the giving of medication to the child who requires medication to be provided during the time in child care.

INTENT: Assuring the health and safety of all children in our Center is a team effort by the child care provider, family, and health care provider. This is particularly true when medication is necessary to the child's participation in child care.

GUIDING PRINCIPLES AND PROCEDURES:

1. Whenever possible, it is best that medication be given at home. Dosing of medication can frequently be done so that the child receives medication prior to going to child care, and again when returning home and/or at bedtime. The parent/guardian is encouraged to discuss this possibility with the child's health care provider.
2. The first dose of any medication should always be given at home and with sufficient time before the child returns to child care to observe the child's response to the medication given. When a child is ill due to a communicable disease that requires medicine as a treatment, the health care provider may require that the child be on a particular medication for 24 hours before returning to child care. This is for the protection of the child who is ill as well as the other children in child care.
3. Medication will only be given when ordered by a child's health care provider and with written consent of the child's parent/legal guardian. A Medication Authorization Form is attached to this policy. All information on the Medication Authorization must be completed before the medication can be given. Copies of this form can be duplicated or requested from the child care provider.
4. "As needed" medications may only be given when the child's health care provider completes a Medication Authorization form that lists specific reasons and times when such medication can be given.
5. Medications given in the Center will be administered by a staff member designated by the Center Director and will have been informed of the child's health needs related to the medication and will have had training in the safe administration of medication.
6. Any prescription or over-the-counter medication brought to the child care center must be specific to the child who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the appropriate information as follows:
 - a. Prescription medication must have the original pharmacist label that includes the pharmacist's phone number, the child's full name, name of the health care provider prescribing the medication, name and expiration date of the medication, the date it was prescribed or updated, and dosage, route, frequency, and any specific instructions for its administration and/or storage. **It is suggested that the parent/guardian ask the pharmacist to provide the medication in two containers, one for home and one for use in child care.**
 - b. Over the COUNTER (OTC) medication must have the child's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible. **The prescription for all over the counter medications must expire within 30 days.**
 - c. ANY OTC medication must have a completed Medication Authorization from the health care provider.
7. Examples of over-the-counter medications that may be given include:
 - a. Antihistamines
 - b. Decongestants
 - c. Non-aspirin fever reducers/pain relievers
 - d. Cough Suppressants
 - e. Topical Ointments, such as diaper cream or Orajel (for topical such as sunscreen/insect repellent be sure the proper permission form is used)



8. All medications will be stored:
 - a. Inaccessible to children
 - b. Separate from staff medications
 - c. Under proper temperature control
 - d. A box will be used in the kitchen to hold medications requiring refrigeration
 - e. All medications not requiring refrigeration will be stored in classroom bathrooms, in the medication box on the highest shelf.
9. For the child who receives a particular medication on a long-term daily basis, the staff will advise the parent/guardian one week prior to the medication needing to be refilled so that needed doses of medication will not be missed.
10. Unused or expired medication will be returned to the parent/guardian when it is no longer needed or able to be used by the child.
11. Records of all medication given to a child are completed in ink and are signed by the staff designated to give the medication. These records are maintained in the Center.
12. Information exchange between the parent/guardian and child care provider about medication that a child is receiving should be shared when the child is brought to and picked-up from the Center. Parents/guardians should share with staff any problems, observations, or suggestions that they may have in giving medication to their child at home, and likewise with staff from the center to the parent/ guardian.
13. Confidentiality related to medications and their administration will be safeguarded by the Center Director and staff. Parents/Guardians may request to see/review their child's medication records maintained at the Center at any time.
14. Parent/guardian will sign all necessary medication related forms that require their signature, and particularly in the case of the emergency contact form, will update the information as necessary to safeguard the health and safety of their child.
15. Parent/guardian will authorize the director to contact the pharmacist or health care provider for more information about the medication the child is receiving, and will also authorize the health care provider to speak with the Center Director in the event that a situation arises that requires immediate attention to the child's health and safety particularly if the parent/guardian cannot be reached.
16. Parent/guardian will read and have the opportunity to discuss the content of this policy with the Director. The parent signature on this policy is an indication that the parent accepts the guidelines and procedures listed in this policy, and will follow them to safeguard the health and safety of their child. Parent/guardian will receive a copy of the signed policy including single copies of the records referenced in this policy upon request.

Parent/legal guardian signature (s):

_____ Date _____

_____ Date _____

References: Information for the Medication Administration in Child Care policy was derived from the current **Manual of requirements for Child Care Centers** in New Jersey and **Caring for Our Children**-The National Health and Safety Performance Standards for Out-of-Home Child Care Programs, second edition.



**MEDICATION AUTHORIZATION FORM FOR MEDICATIONS,
DIAPER CREAM AND TOPICAL LOTIONS**

(Please use one form per medication)

The following information is to be completed by the child’s health care provider:

Child’s Name: _____
Birth date: _____ Wt: _____
Medication: _____ Allergies: _____
Dosage: _____ Route: _____
Time of day medication is to be given: _____
Purpose of medication: _____
Special Instructions: _____
Possible Side Effects: _____
Start Date: _____ End date: _____

Signature of Health Care Provider Phone Number Date

The following is to be completed by the Parent or Guardian:

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child’s full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine. **I authorize the Director to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director to contact the health care provider regarding my child’s health if necessary.**

I usually do the following to make giving medication to my child easier:

Amount of medication brought to Child Care: _____

Date Signature of Parent or Guardian

Date and amount of medication returned to parent _____

Signature of Director Signature of Parent/Guardian



AUTHORIZATION FOR DIAPER CREAM AND TOPICAL LOTIONS

This section is to be completed by Parent/Guardian:

Name of Child: _____ Birth date: _____
Health Care Provider Name: _____ Phone Number: _____
Health Care Providers Address: _____
Name of Medication: _____ Purpose: _____
Times to be applied: _____
Amount to be applied: _____
Where should be lotion be applied: _____
Special instructions: _____
Possible Side Effects: _____
Start Date: _____ End Date: _____

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. **I authorize the Director to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director to contact the health care provider regarding my child's health if necessary**

*For over the counter creams and lotions, this form must be completed annually or with a change in brand.

Signature of Parent/Guardian

Date



AUTHORIZATION FOR SUNSCREEN & INSECT REPELLENT

Child's Name: _____ Birth date: _____
Name of Health Care Provider: _____ Phone Number: _____
Allergies: _____

I hereby grant permission to Lightbridge Academy Child Care, or any staff that they designate able, to apply sunscreen on my child _____ . I understand that the sunscreen will be applied on days that my child is participating in outdoor play. I also am aware that it is my responsibility to provide the sunscreen to Lightbridge Academy.

Name of Sunscreen: _____

Application Directions: _____

I hereby grant permission to Lightbridge Academy Child Care, or any staff that they designate able, to apply insect repellent on my child _____ . I understand that the insect repellent will be applied by request of parent/guardian on days that my child is participating in outdoor play. Insect repellent will be applied to summer camp children on all trip days. I am also aware that it is my responsibility to provide the insect repellent to Lightbridge Academy.

Name of insect repellent: _____
Application Directions: _____

Parent Signature: _____
Date: _____



Child Image Usage Consent Form

This parental consent form serves to both inform you and to request permission for your child's photo/image and personally identifiable information to be published online, including our public website, social media sites, other Internet sites and to be used for Lightbridge Academy publicity purposes.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the director of your child's center and such rescission will take effect upon receipt.

Check one of the following choices: _____ I/We GRANT or _____ DO NOT GRANT permission for my child's photo/image to be used.

Child's Name: _____

Classroom: _____

Parent Name (Print): _____

Parent Signature: _____ Date: _____



CHILD'S FILE CHECKLIST (FOR OFFICE USE ONLY)

Child's Name _____
 Birth date _____ Enrollment Date _____

- _____ Signed Registration Form (includes :)
- Name, Birth Date, Address, Enrollment Date
 - Parent Employer Info
 - Emergency Contact Phone Numbers
 - Permission for Medical Emergencies
 - Signature confirming Info to Parents Document
 - Signature Confirming Expulsion Policy
 - Email Address
- _____ Universal Health Record w/ Doctor's Name & Phone
- Prescription if applicable: _____
 - _____ Immunization Record
 - _____ Custody Documents if applicable
 - _____ Emergency Contact Form
 - _____ EFT Authorization Form
 - _____ Financial Agreement
 - _____ Identification Form
 - _____ Id from parent 1: _____
 - _____ Id from parent 2: _____
 - _____ Medication Administration Policy
 - _____ Child Image Usage Consent Form

- If needed:
- _____ Special Care Plan for Children w/ Special Health Needs
 - _____ Food Allergy Action Plan
 - _____ Asthma Action Plan

-
- _____ Given Parent Handbook/Signature
 - _____ Given Non-discrimination in services letter
 - _____ Entered into QuickBooks
 - _____ Entered into Procure
 - _____ Entered into Tadpoles
 - _____ Entered EFT paperwork into Bank
 - _____ Added to the appropriate place on the Class List
 - _____ Added to Lunch plan (Reg or Veg)
 - _____ Added to Pizza list
 - _____ Given extracurricular sign up forms
 - _____ Given Placemat and Primary Care Giver Card to classroom teachers
 - _____ Check if in database, if so mark enrolled
 - _____ Add Emergency Contact Form to Office Emergency Binder
 - _____ Give copy of the Emergency Contact Form to the child's classroom teachers
 - _____ If any allergies or food restrictions, add to list, print updated Allergy list
 - _____ If signing up for extracurricular classes, or optional services, add to list and print updated lists
 - _____ If custody issues add to list and print report.
 - _____ If permission to use photo is not approved, add to Do Not Photograph Quick List

Permission to use photo for school publicity <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____
--

Permission to send child's photo via the tadpoles system. <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____

File Completed Date: _____ Initials: _____