TEXAS Health and Human Services

January 2019-E Form 2935

Admission Form

Operation's Name:		Director's Name:	
Child's Full Name	Child's Date of Birth	Email:	
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)		
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Cell Phone 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 the 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	Phone Number
Name	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 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.

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

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 (CCL), DFPS Child Abuse Hotline, and CCL 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:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday From: _____ To:_____

7. Sunscreen/ Insect Repellent Application- if you would like for the daycare to apply sunscreen/ insect repellent to your child, please provide us with an unexpired bottle of both. Please make sure your child's first and last name is clearly marked on both bottles. As with any topical medication cream or spray, the first application of any brand of sunscreen/ insect repellent should be applied at home in order to evaluate your child's possible allergic reaction to that product.
I give consent for the daycare to apply: ☐ Sunscreen ☐ Insect Repellent

8. Pictures/ Videos- throughout the year, the teachers and office staff may take pictures/videos of the children engaged in activities and field trips. Some of these photos may be posted on the daycare's social media and website and used for marketing material as well. We think the students will be proud and excited to see themselves online and will really enjoy sharing their accomplishments with others, especially if they have family members who live out of town. The student's last names will never be used to caption their photos.
☐ I give consent to the daycare to use my child's picture/video on their social media and website
☐ I do not give consent to the daycare to use my child's picture/video on their social media and website

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	School Phone Number

My child has permission to (check all that apply): ☐ walk to or from school or home ☐ ride a bus

☐ My child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

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. 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.

_____ _____

Signature — Healthcare Professional 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	Address of Health Care Professional

_____ _____

Signature — Parent or Legal Guardian Date Signed

Immunizations

☐ I have provided the childcare operation with a copy of my child's most current immunization record

Varicella (chicken pox)

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.

_____

Signature — Parent or Legal Guardian

Signatures

_____ _____

Child's Parent or Legal Guardian Date SIgned

_____ _____

Center Designee Date Signed

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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:_____

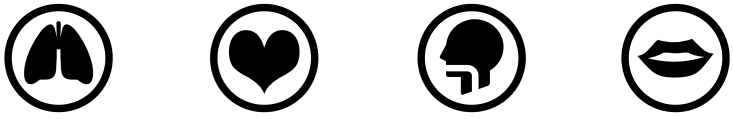
THEREFORE:

☐ 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

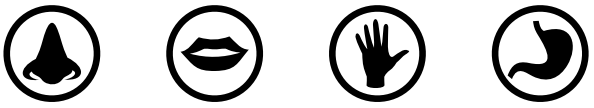
OTHER
Feeling something bad is about to happen, anxiety, confusion

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: ☐ 0.1 mg IM ☐ 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

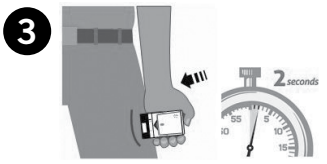
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

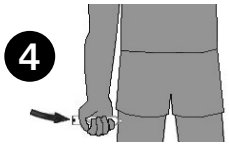
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



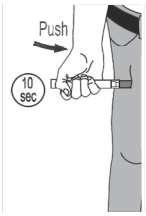
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: Anita Moreau Food Program Specialist Agreement Number: _____

Facility/Provider Name: Discovery Kidz

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 eligibility 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;

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

This institution is an equal opportunity provider.

Little Steps
1-5 Year Child Info Sheet

This form if for the purpose of gathering information about your child that will help your child's primary teacher meet his/her needs. All responses will be shared with your child's immediate caregivers.

Foods your child especially likes: _____
Foods your child dislikes: _____
Food Allergies or Intolerances you child has: _____

The child lives with: □ Both Parents □ Mother Only □ Father Only □ Guardian

Please list other members of the household:

Name	Relationship	Birthdate
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's position in the family: _____
How would you describe your child's disposition? _____
_____
Please describe any health problems or concerns: _____
_____

Please answer the following to the best of your knowledge:

Infant Background- Age at which child first…

Sat Alone _____ Crawled _____ Walked _____ Spoke First Word _____
Was your child breast fed? YES/NO If so, how long? _____

Toddler and Preschool Background- My child…

□ Speaks in sentences Began at what age? _____
□ Feeds self with spoon
□ Drinks from a cup
□ Has control of bladder Begin at what age? _____
□ Has control of bowels Begin at what age? _____

What method did or are you using to toilet train your child? _____
_____
What words does your child use to indicate toileting needs? _____
_____

Parent Signature: _____ Date: _____

Horizons Ministry
Tuition Contract

Select School:

▢Discovery Kidz	▢Little Steps	▢New Horizons	▢Kaleidoscope Kids
3901 Spencer Hwy #150 Pasadena, Tx 77504	6901 Fairmont Parkway Pasadena, Tx 77505	5151 East Sam Houston Pkwy S, Pasadena, TX 77505	5750 S Rice Ave, Houston, TX 77081

Child's Name: _____
Parent's Name:_____
Tuition:_____

NOTICE: NCI Parents MUST be on a monthly billing cycle

Please select one of the following payment cycles: ▢ weekly ▢ bi-weekly ▢ monthly

The following are our tuition policies:

1. Parents may choose to pay tuition on a weekly, bi-weekly, or monthly basis.Payment for tuition can be made in any amount as long as it is over the amount of one week's tuition. Registration and activity/supply fees should be paid upon enrollment or prior to the start date of attendance.
2. Tuition is paid in advance and due on the following payment basis:
   Weekly- Due on Monday morning for the following week. If a holiday falls on Monday, payment will be due Tuesday.
   Bi-Weekly- Due on or before the 1st and 15th of every month. If a holiday falls on the 1st or the 15th, payment will be due on the next business day.
   Monthly- Due on the 1st of every month. If a holiday falls on the 1st, payment will be due the next business day.
   NCI Families- Your parent fee is due the 1st of every month, if other arrangements need to be made please speak with the office staff.
3. Late fees: $10.00 will be charged to unpaid accounts on the 3rd business day of the billing cycle. Account balances that remain unpaid in the next billing cycle will be charged a $10.00 fee again until the account is brought current. A 30 day notice letter will be sent to notify you of the delinquent account. We reserve the right to dismiss the child if the account is not brought current.
4. A late pick up fee of $1.00 per minute/per child will be assessed after 6:00pm and has to be paid in cash the following day.
5. A $25.00 fee will be charged on checks that are returned from the bank. We will only accept money orders, or cashiers checks on accounts that have two returned checks.
6. There will be **no reduction in tuition due to an absence other than vacation** (see Parent Handbook) **This includes sick days, holidays, in-service days, or emergency measures.** Absences do not warrant a reduction in tuition since the school must incur its operating costs whether a child attends or not.
7. A two week notice is required in writing prior to your child's last day.
8. Parents who fail to pay tuition on time are subject to be reported into a payment violations network that reports to credit bureaus.

I have read and acknowledge the policies regarding policies and payments of tuition as stated above.

_____ _____
Parent's Signature Date

_____ _____
Faculty Representative's Signature Date

TEXAS Health and Human Services

Form 2987
October 2023

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

(1) enter and examine the child care facility during the facility's hours of operation without advanced notice;

(2) review the child care facility's publicly accessible records;

(3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;

(4) obtain a copy of the child care facility's policies and procedures;

(5) review, at the request of the parent or guardian, the facility's:

(A) staff training records; and

(B) any in-house staff training curriculum used by the facility;

(6) review the child care facility's written records concerning the parent's or guardian's child;

(7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:

(A) video recordings of the alleged incident are available;

(B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and

(C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;

(8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;

(9) be provided the contact information for the child care facility's local Child Care Regulation office;

(10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and

(11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature of Parent or Guardian **Date**

Resources

Facility Information and Online Compliance History: http://txchildcaresearch.org

Child Care Regulation Contact Information: https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation

Automated Payment Processing

Procare SOLUTIONS

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) _____ 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. 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

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