



A Ministry of Cathedral of Faith

WELCOME TO MY SCHOOL

WHAT TO BRING FOR ENROLLMENT

- ❑ **Birth Certificate**

- ❑ **Immunization Records**

WHAT TO BRING FOR YOUR CHILD

Back Pack

Bring 3 changes of weather appropriate clothing and an extra pair of shoes. This should include underwear/ panties & socks as well.

Lunch

Bring a cold lunch from home (no warm up's please) ice packs will help keep food cold until lunch time.

Bedding

To comply with state licensing all children need to have a fitted crib/ toddler sheet and small blanket for nap. You can also bring a small pillow, stuffed animal or doll for naptime if it helps your child rest comfortably.

2's & young 3's who are not potty trained

Parents' it is your responsibility to provide diapers for your child. Plan for your child to be changed 3 to 5 times a day. You may bring diapers in daily or in bulk. Please be sure to label them so they don't get mixed up with another child. The teacher will inform you when you're getting low on diapers and need to bring more. If your child comes to school and is out of diapers we will call you and expect you to bring some in with in the same day. Plan replenish any diapers that may have been borrowed. My School provides Costco brand wipes. If your child has sensitive skin and needs a different brand of wipes, it will be your responsibility to provide them.

* Please do not bring pull-ups, pacifiers, bottles or sippy cups.

Thank-you ☺

My School Enrollment Application

Today's Date: ___/___/___

Requesting Enrollment Beginning: ___/___/___ D.O.B: ___/___/___

Child's Name: _____

Child's Nickname: _____ Child's Age: _____

Home Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Mom's Cell: _____

Father's Cell: _____

FAMILY BACKGROUND

Father's Name: _____ Living with child? Y / N

Occupation: _____ Work Phone: _____

Employer: _____ Church Membership: _____

E-mail Address: _____

Signature: _____

Mother's Name: _____ Living with child? Y / N

Occupation: _____ Work Phone: _____

Employer: _____ Church Membership: _____

E-mail Address: _____

Signature: _____

Siblings

Name: _____ Birthdate: ___/___/___

Name: _____ Birthdate: ___/___/___

PRIOR DAYCARE EXPERIENCE:

Name of Center/Caregiver: _____

Address: _____ Phone #: _____

Length of Attendance: _____ Reason for leaving program? _____

How did you hear about My School? _____

My School Financial Agreement

Student Name: _____

Person Responsible for Tuition:

Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____

Registration Fee: \$100.00
Sibling Registration Fee: \$55.00
Annual Registration Fee: \$55.00 per child

* These fees are non-refundable.

Monthly Rates: Payments will be automatically withdrawn from FACTS each month. Please indicate which schedule you are requesting.

<u>Not Potty Trained 2year olds</u>	<u>Potty Trained</u>
_____ 5 Full Days \$1135.00	_____ 5 Full Days \$895.00
_____ 4 Full Days \$925.00	_____ 4 Full Days \$775.00
_____ 3 Full Days \$805.00	_____ 3 Full Days \$670.00
_____ 2 Full Days \$680.00	_____ 2 Full Days \$570.00
_____ 5 Morning Days \$875.00	_____ 5 Morning Days \$695.00
_____ 4 Morning Days \$750.00	_____ 4 Morning Days \$570.00
_____ 3 Morning Days \$620.00	_____ 3 Morning Days \$490.00
	_____ 2 Morning Days \$390.00

Full Day hours are 7:00 a.m. to 6:00 p.m. Morning Day hours are 7:00a.m. to 12:00p.m.
Please pick your child up on time. Late pick-ups will be charged an overtime fee.

Absentee / Holiday policy: There is no refund or adjustment to tuition. Your tuition ensures that your child has a spot.

Withdrawal: 30 days written notice is required to avoid full payment of the following month.

Discounts: 10% discount on tuition for each additional sibling.

Scheduled Days
M T W T H F

I understand and agree to all of the contract terms.

(X) _____
 Signature of the person responsible for tuition

_____ Date
 Please print name of person who signed.

(X) _____
 Administrative Signature

Discount Receiving

Discount: _____

Orig. Tuition: _____

Disc. Amount: _____

Actual Amount: _____

My School Financial Agreement

Student Name: _____

Person Responsible for Tuition:

Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____

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_____ 5 Morning Days \$875.00	_____ 5 Morning Days \$695.00
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 Signature of the person responsible for tuition

_____ Date
 Please print name of person who signed.

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 Administrative Signature

Discount Receiving

Discount: _____

Orig. Tuition: _____

Disc. Amount: _____

Actual Amount: _____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/DOMESTIC PARTNER'S NAME		DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/DOMESTIC PARTNER'S NAME		DOES MOTHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* MONTHS	BEGAN TALKING AT* MONTHS	TOILET TRAINING STARTED AT* MONTHS
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PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES? ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN? AAAaaa

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S/DOMESTIC PARTNER'S SIGNATURE	DATE
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CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

#

DATE

PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

()

WORK PHONE

()

Parent / Guardian's Permission to Apply Sunscreen to His / Her Child

Name of Child: _____
(last, first)

As parent / guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer. Therefore, I give permission for the staff at: *My School* to apply *Banana Boat Kids Tear Free SPF 50* brand sunscreen that has a broad spectrum with SPF 15 or higher, as specified below, when he / she will be playing outside, especially during the months of May through October. I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eye lids), tops of ears, nose, bare shoulders, back of neck, arms and legs.

I have checked and initialed below all applicable information regarding My Schools' choice in brand / type and use of sunscreen for my child:

_____ My child is allergic to the sunscreen brand that My School is providing, therefore I will provide the following brand / type of sunscreen for use for my child.

_____ I understand that My School will only apply sunscreen for the afternoon recess (between 2:30 – 4:30) Therefore it is my responsibility to apply sunscreen to my child in the morning before dropping them off at school, doing this will ensure they are protected from harmful UV rays during the AM recess.

Parent / Guardian's Name: _____ Date: _____

Parent / Guardian's Signature: _____

Health Care Provider's Signature (optional) _____

* NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter _____

(NAME OF CHILD)

(BIRTH DATE)

My School

(NAME OF CHILD CARE CENTER/SCHOOL)

This Child Care Center/School provides a program which extends from 7:00

a.m./p.m. to 6:00 a.m./p.m. 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT/DOMESTIC PARTNER, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware: _____

Hearing: _____ Allergies: medicine: _____

Vision: _____ Insect stings: _____

Developmental: _____ Food: _____

Language/Speech: _____ Asthma: _____

Dental: _____

Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
VMMR (MEASLES, MUMPS, AND RUBELLA) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

See Attached

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

have have not reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature: _____

Physician Physician's Assistant Nurse Practitioner

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), domestic partner(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME <u>San Jose Community Care Licensing</u>		
ADDRESS <u>2580 N. First street, Suite 300</u>		
CITY <u>San Jose CA,</u>	ZIP CODE <u>95131</u>	AREA CODE/TELEPHONE NUMBER <u>408-324-2148</u>

DETACH HERE

TO: PARENT/DOMESTIC PARTNER/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY) <u>My school / Cathedral of Faith</u>	(PRINT THE ADDRESS OF THE FACILITY) <u>2315 Carnoas Garden Ave, S.J. CA, 95128</u>
(PRINT THE NAME OF THE CHILD)	

(SIGNATURE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)	
(TITLE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)	(DATE)

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Domestic Partner/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: San Jose Community Care Licensing
 Licensing Office Address: 2580 N. First Street, Suite 300, S.J. CA. 9513
 Licensing Office Telephone #: (408) 324-2148

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (1/08)

(Delach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Domestic Partner/Authorized Representative Signature Required)

I, the parent/domestic partner/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

My School / Cathedral of Faith
Name of Child Care Center

Signature (Parent/Domestic Partner/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/domestic partner/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov



My School

A Ministry of Cathedral of Faith

MY SCHOOL TALENT RELEASE

I, the undersigned, do hereby give consent to the Cathedral of Faith/My School to use my and/or my child's name, voice and likeness, including but not limited to any and all photographs, video tapes and audio tapes, and/or other audio-visual materials taken of me and/or my child by or on behalf of the Cathedral of Faith/My School, for any and all purposes, including private video and public broadcast.

Signature: _____

Printed Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Child's Name: _____

Relationship to Child: _____

Date: ____/____/____

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES
To Be Completed by Parent, Domestic Partner or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
MOTHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ()
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT, DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE

DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION

DATE LEFT



Child's Information Sheet



Child's Name _____ Birth Date: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Child lives with: Mom: _____ Dad: _____ Step-parent: _____

Grand-parents: _____ Guardian: _____

Church attending: _____

Siblings: (name & age) _____

Child's Interest and hobbies: _____

Child's Strengths: _____

Child's Weaknesses: _____

Health Conditions: (sinus, allergies.) _____

Does child like music and sings: _____

What is the goal for your child?

Academically: _____

Spiritually: _____

Please fill this out and give to the teacher whom your child is with. Thank you so very much.

Parent Handbook 2011

Acknowledgement: I _____, parent of
_____ have received a copy of the
My School parent handbook. I agree to abide by all the policies
and rules. I'm also aware of the school calendar and school
closures.

- Due upon receiving handbook.

X _____ Date: _____
(Signature of the representative/ parent/ guardian)

FOOD ALLERGIES

HAS THE FOLLOWING FOOD ALLERGIES:

CHILD'S NAME _____

HIS/ HER REACTION TO THE FOOD ALLERGIES IS AS FOLLOWS:

DATE _____

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE _____

EMERGENCY PHONE _____
