



## ADMISSION ENROLLMENT CHECKLIST FOR THE 2021-2022 SCHOOL YEAR

Child's Name: \_\_\_\_\_

Class: \_\_\_\_\_

### CHECK AS COMPLETED:

- Enrollment Application Form
- Enrollment Contract Signed
- Medication Permission Form
- Prescribed & Over-the-Counter Medication Profile
- Food Allergy Action Plan
  - Food Allergies: \_\_\_\_\_
  - EpiPen? \_\_\_\_\_
- Video & Photo Consent:
  - Yes or No -> Comments: \_\_\_\_\_
- Parent Handbook (Signature Required)
- Parties & Celebrations Form
  - Yes or No -> Comments: \_\_\_\_\_

### FOR OFFICE USE

- Department of Health Form 3040 (School Physical) Expires: \_\_\_\_\_
- Department of Health Form 680 (Immunization) Expires: \_\_\_\_\_
- Program: 10 months: \_\_\_\_\_ | 12 months: \_\_\_\_\_ | Before Care/After Care: \_\_\_\_\_
  - Entered in Tuition Management System
  - Application Fee: \$ \_\_\_\_\_
  - Registration: \$ \_\_\_\_\_
  - Instructional Fee (Elementary only): \$ \_\_\_\_\_
  - TimberNook Licensing Fee (optional): \$ \_\_\_\_\_





**Additional Persons Authorized to Pick Your Child Up & Emergency Contacts** (other than parent/guardian):

Important: Child will be released only to the parent or legal guardian, and persons listed below. The following people will also be contacted and are authorized to remove your child from the facility in case of illness, accident or emergency if the parent or legal guardian cannot be reached. Please introduce us to the persons authorized to pick your child. For the safety of your child, please notify teachers (verbally or in writing) of who will be picking up your child. We will request a photo ID from someone listed below whom we have not previously met before releasing your child to them. Please list the name, relationship, and phone number for ALL individuals who are permitted to remove your child from Palm Valley Child Development Center property:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please make a 4-digit code that will be used for pick up purposes only. This is a number that you make up and give to people authorized to pick up your child.

Authorized Pick-up → **4-Digit Code:** \_\_\_\_\_

**AS PARENT/GUARDIAN OF THE ABOVE, I VERIFY THAT THE INFORMATION ON THIS ENTIRE DOCUMENT IS CURRENT, THAT I WILL IMMEDIATELY INFORM THE SCHOOL OF ANY CHANGES IN THIS INFORMATION AND I WILL BE RESPONSIBLE FOR TUITION, FINES, OR PENALTIES, ATTORNEY'S FEES AND COURT COSTS RESULTING FROM A FALSIFIED DOCUMENT. I AUTHORIZE THE SCHOOL PERSONNEL TO TAKE RESPONSIBLE EMERGENCY MEASURES, INCLUDING CALLING 911, ON BEHALF OF MY CHILD AND AGREE TO HOLD THEM HARMLESS FOR ANY TREATMENT RENDERED.**

**Section 3: Medical Information**

Signature of Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Full Legal Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Physician's Telephone: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Dentist's Telephone: \_\_\_\_\_

Please list any allergies, medical conditions, developmental delays or medications currently being taken, including dietary requirements, allergies to medication, or any other limitations: \_\_\_\_\_

I hereby give permission in the event of an emergency for the Director, the Acting Director, or a Teacher at Palm Valley Child Development Center, to take whatever steps may be necessary for the medical care of my child, \_\_\_\_\_. I understand that in order for Palm Valley Child Development Center to assume responsibility of my child, I, or the person(s) whom I have designated to drop off and pick up my child, must sign my child in at the time of arrival and out at the time of departure. I understand that unless there is a need for immediate action, the order of the steps taken will follow, but will not be limited to, the outline below: 1. The parent/guardian will be called. Note: If the parent/guardian is unavailable, the emergency contact persons designated by the parent/guardian will be called. 2. Child's physician will be called. 3. If these efforts are unsuccessful, the following steps will be taken (order may vary depending on the situation): a. Another physician will be called. B. The child will be taken to the nearest emergency room accompanied by a staff member. C. An ambulance will be called to take the child to the nearest emergency room accompanied by a staff member. If I cannot be reached in the event of an emergency, I give consent to Palm Valley Child Development Center staff member to transport my child to the nearest emergency facility, or to have my child transported by ambulance. I give consent to any emergency facility or physician to administer any necessary medical treatment to my child as the situation may warrant it. I further understand that I am responsible to any and all costs associated with any and all medical treatments for my child. Parent/Guardian confirms that they will hold Palm Valley Child Development Center and its staff harmless from any liability which might arise from this consent. Parent/Guardian agrees to reimburse Palm Valley Child Development Center for any medical Expenses that may arise while child is in our care.

Signature of Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



#### Section 4: Student Profile/ Background Information

(Please feel free to add additional pages if necessary)

Child born prematurely?  Yes  No If YES, how many months early? \_\_\_\_\_ Child's place of birth: \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

List child's siblings and their ages: \_\_\_\_\_

Please list any other members of your household (pets, tool) by name, age and relationship: \_\_\_\_\_

If child is adopted, list age at time of adoption: \_\_\_\_\_ Is child aware of adoption? \_\_\_\_\_

Is your child toilet trained? \_\_\_\_\_ If in progress, explain: \_\_\_\_\_

Describe assistance needed and words used: \_\_\_\_\_

Has your child previously attended school? \_\_\_\_\_ If so, where \_\_\_\_\_

Please describe any health issues that we should be aware of: \_\_\_\_\_

Please describe any special dietary needs that we should be aware of and describe your child's appetite: \_\_\_\_\_

What methods of behavior management are used in your home? \_\_\_\_\_

Does your child attend any sort of therapy? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Please describe any serious operation or accident your child may have had: \_\_\_\_\_

Please list all medications your child takes on a regular basis and the associated conditions: \_\_\_\_\_

Please describe any special medical, physical or emotional needs that the school and staff should be aware of: \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

What does your child enjoy doing with Mother? \_\_\_\_\_

What does your child enjoy doing with Father? \_\_\_\_\_

Does your child play well alone? \_\_\_\_\_ In groups? \_\_\_\_\_

As a parent, what do you feel you can do to avoid an unpleasant first day at school? \_\_\_\_\_



**KNOW YOUR CHILD CARE FACILITY BROCHURE  
PARENT ACKNOWLEDGMENT**

I have received and read a copy of the “Know your Child Care Facility”  
(pgs 6-8)

Child’s Name: \_\_\_\_\_

Parent/Guardian Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## KNOW YOUR CHILD CARE FACILITY

### PARENT'S ROLE

A parent's role in quality child care is vital:

- Inquire about the qualifications and experience of child care staff, as well as staff turnover
- Know the facility's policies and procedures
- Communicate directly with caregivers
- Visit and observe the facility
- Participate in special activities, meetings, and conferences
- Talk to your child your child about their daily experiences in child care
- Arrange alternate care for their child when they are sick
- Familiarize yourself with the child care standards used to license the child care facility

### MORE INFORMATION AND FREE RESOURCES

[MyFLFamilies.com/ChildCare](https://myflfamilies.com/ChildCare)

**This child care facility is licensed according to the minimum licensure standards included in section 402.305, Florida Statutes (F.S.), and Chapter 65C-22, Florida Administrative Code (F.A.C).**

License Number: 1081715

License Issued on: 09/30/2020

License Expires on: 09/30/2021

For more information regarding the compliance history of this child care provider, please visit:

[myflfamilies.com/childcare](https://myflfamilies.com/childcare)

To report suspected or actual cases of child abuse or neglect, please call the Florida Abuse Hotline at 1-800-962-2873  
CF/PI 175-24/-3/2014

**This brochure was created by the**

Florida Department of Children and Families,  
Office of Child Care Regulation and Background Screening

Pursuant to s. 402.3125(5). F.S.,

License #C07SJ0120 || License issued on 7/18/2018 || License expires on: 7/17/2019

Palm Child Development Center

185 Landrum Ln, Ponte Vedra Beach, FL 32082

2021-2022 School Year



## GENERAL REQUIREMENTS

Every licensed child care facility must meet the minimum state child care licensing standards pursuant to s.402.305, F.S, and Ch. 65C-22, F.A.C., which include, but are not limited to, the following:

- Valid license posted for parents to see
- All staff appropriately screened
- Maintain appropriate transportation vehicles (if transportation is provided)
- Provide parents with written disciplinary practices used by the facility
- Provide access to the facility during normal hours of operation
- Maintain minimum staff-to-child ratios

## PALM VALLEY CHILD DEVELOPMENT CENTER RATIOS

AGE GROUP  
Elementary

FOUNDATION GOAL  
10:1 (with Assistant)

## HEALTH RELATED REQUIRMENTS

Emergency procedures that include

- Posting Florida Abuse Hotline number along with other emergency numbers
- Staff trained in first aid and Infant/Child CPR on the premises at all times
- Fully stocked first aid kit
- A working fire extinguisher and documented monthly fire drills with children and staff
- Medication and hazardous materials are inaccessible and out of children's reach

## TRAINING REQUIREMENTS

- 10-hour in-service training annually
- Director Credential for all facility directors



## RECORD KEEPING

Maintain accurate records that include:

- Children's health exam/immunization record
- Medication records
- Enrollment information
- Personnel records
- Daily attendance
- Accidents and incidents
- Parental permission for field trips and the administration of medications

## PHYSICAL ENVIRONMENT

- Maintain sufficient usable indoor floor space for playing, working, and napping
- Provide space that is clean and free of litter and other hazards
- Maintain sufficient lighting and inside temperatures
- Equipped with age and developmentally appropriate toys
- Provide appropriate bathroom facilities and other furnishings
- Provide isolation area for children who become ill
- Practice proper hand washing, toileting, and diapering activities

## QUALITY CHILD CARE

Quality child care offers healthy, social, and educational experiences under qualified supervision in a safe, nurturing, and stimulating environment. Children in these settings participate in daily, age-appropriate activities that help develop essential skills, build independence and instill self-respect. When evaluating the quality of a child care setting, the following indicators should be considered.

## QUALITY ACTIVITIES

- Children initiated and teacher facilitated
- Include social interchanges with all children
- Children expressive including play, painting, drawing, storytelling, music, dancing, and other varied activities
- Include exercise and coordination development
- Include free play and organized activities
- Include opportunities for all children to read, be creative, explore, and problem-solve





## FLU FORM SIGNATURE REQUIRED

During the 2009 legislative session, a new law passed that required child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date Received: \_\_\_\_\_

Signature: \_\_\_\_\_

Please complete and return this portion of the brochure to your child care provider, in order for the to maintain it in their records.

### WHAT SHOULD I DO IF MY CHILD GETS SICK?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

### CALL OR TAKE YOUR CHILD TO A DOCTORS RIGHT AWAY IF YOU CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse



## WHAT IS THE INFLUENZA (FLU) VIRUS?

Influenza (“the flu”) is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life-threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

## HOW CAN I TELL IF MY CHILD HAS A COLD OR THE FLU?

Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

## HOW CAN I PROTECT MY CHILD FROM THE FLU?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19<sup>th</sup> birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.



## WHAT CAN I DO TO PREVENT THE SPREAD OF GERMS?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Through much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth

## WHEN SHOULD MY CHILD STAY HOME FROM CHILD CARE?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group settings until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

For additional helpful information about the dangers of the flu and how to protect your child, **visit [cdc.gov/flu/](https://www.cdc.gov/flu/) or [immunizeflorida.org](https://www.immunizeflorida.org)**



## MEDICATION PERMISSION FORM

If your child required medication during their time at school, the rules must be observed:

- Sign this document as evidence of your consent
- Complete the following medication profile for your child
- A separate authorization form must be completed for each medication administered

There shall be no liability for civil damages as a result of the administration of such medication when the person administering such medication acts as a reasonably prudent person would act under the same circumstances.

**Medication must be in the original pharmacy-labeled bottle.**

**Non-prescription or Over-The-Counter (OTC) medication must be in the original packaging with the manufacture's label.**

**When medication is discontinued, or a course of medicine is completed, pick up all unused medication within one week. Unclaimed medications will be destroyed.**

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As legal parent or guardian, I hereby give permission for (Child's Name) \_\_\_\_\_  
to take the medication that I am providing and authorize the school to store these medications according to school policies, and administer the medication to my child as directed. I further agree to inform Palm Valley Child Development Center of any changes in medication, including changes in when the medication is taken, change in dosage, a new or different medication is prescribed, any reaction to the medication, or discontinuation of the medication. I further understand that this consent applies to all medication, whether it is prescribed or purchased over the counter without a prescription. I understand that this consent is valid for one year from the signed date.

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Print Parent/Guardian's Name

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Parent/Guardian's Signature

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Date



## MEDICATION PROFILE 2021-2022

### PRESCRIBED AND OVER-THE-COUNTER

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Medication Dose: \_\_\_\_\_ Time to Administer: \_\_\_\_\_

Method of Administration: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Indication for use: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

How long will your child need to take this medication? \_\_\_\_\_

**When medication is discontinued, or a course of medicine, is completed, pick up all unused medication within one week. Unclaimed medications will be destroyed.**



## PREScribed AND OVER-THE-COUNTER MEDICATION PROFILE 2021-2022

Child's Name: \_\_\_\_\_

Medication/Sunscreen Name: \_\_\_\_\_

Date & Time

Amount

Employee

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



## FOOD ALLERGY ACTION PLAN

### 2021-2022 SCHOOL YEAR

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergy To: \_\_\_\_\_

Asthmatic (circle): Yes\* | No | No Known Allergies

*\*Higher risk for severe reaction*

### 1: Treatment

**Symptoms:**

**Give Checked Medication\*\***

\*\* (To be determined by physician  
authorizing treatment)  
(Circle One)

If a food allergen has to be ingested but no symptoms	Eprinephrine	Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, or mouth	Eprinephrine	Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	Eprinephrine	Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	Eprinephrine	Antihistamine
Throat: Tightening of throat, hoarseness, hacking cough	Eprinephrine	Antihistamine
Lung: Shortness of breath, repetitive coughing, wheezing	Eprinephrine	Antihistamine
Heart: Weak or thready pulse, low blood pressure, fainting, pale or blueness	Eprinephrine	Antihistamine
Other:	Eprinephrine	Antihistamine
If reaction is progressing (several of the above areas affected), give:	Eprinephrine	Antihistamine



**Dosage: Epinephrine: Injected intramuscularly (circle one):**

**EpiPen**

**Jr.Twinject.03mg**

**Twinject 0.15mg**

**Palm Valley Child Development Center requires that 2 epi pens be provided**

Antihistamine: give \_\_\_\_\_

Other: give \_\_\_\_\_

Important: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

## Step 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Doctor: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

3. Parent: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

4. Emergency Contacts:

Name/Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## PHOTO/VIDEO WAIVER FORM

### 2021-2022 SCHOOL YEAR

Child's Name: \_\_\_\_\_

#### PHOTO:

I give permission for my child (named above) to have photos taken by Palm Valley Child Development Center for school or website use (circle one):

- I do give consent
- I do not give consent

#### PHOTO for Classroom:

I give permission for my child (named above) to have photos taken by Palm Valley Child Development Center for classroom use (circle one):

- I do give consent
- I do not give consent

#### VIDEO:

I give permission for my child (named above) to be videotaped by Palm Valley Child Development Center for school or website use (circle one):

- I do give consent
- I do not give consent

I have read this entire waiver, fully understand it, and agree to be legally bound by its terms. Should my wishes change, I will notify a Palm Valley Child Development Center staff member. The most recent consent waiver will be honored.

Parent/Guardian Name (please print): \_\_\_\_\_

Date: \_\_\_\_\_



## CONSENT FOR HYGIENE PROCEDURES

Palm Valley Child Development Center (PVC) is committed to working with our families to provide the optimum level of care for all students. PVC has a health and hygiene policy to create and maintain a safe and healthy learning environment.

By signing the form below, I consent to my child receiving support in the area of health and hygiene in the following scenarios:

- Toileting (i.e., handwashing, soiling of clothing, etc.)
- Changing of clothes (i.e., Water day; TimberNook; after soiling clothes)
- As part of an Education Plan (i.e., PEP goals- brushing teeth and hair)
- After TimberNook (i.e., washing of the skin, hair, face; changing of clothing as needed)

Due to the nature of TimberNook our students often get really dirty. Our first method is to rinse them off with the hose and/or use handwipes. However, if that method is not effective, there are showers available for use in accordance with DCF standards. One outdoor shower is located at Collage and one private shower is located at PVC which can be used if necessary or preferred to achieve a more adequate cleaning.

In the event your child needs assistance with any hygiene procedures of the incidents listed above, the following supports will be implemented to aid and coach students on developing independent functioning skills.

- All procedures will take place with at least two adults present.
- A hands-off approach will be taken for all procedures to the greatest extent possible based on each child's unique abilities.
- If a shower is necessary to achieve sufficient cleanliness, a bathing suit will be used when available during the cleaning process.
- Communication will be sent home regarding change of clothes and/or rinsing off in the shower.

I understand the constant form above and give my permission for the Hygiene Management Procedures to be used as specified in this document for the remainder of the 2021-2022 School Year.

If a shower is required to achieve sufficient cleanliness, I DO  or DO NOT  require my child to wear bathing suit.

I DO NOT give my permission for PVC staff to assist my child with the following Hygiene Management Procedures:

\_\_\_\_\_ changing clothes

\_\_\_\_\_ rinsing off in shower (washing skin, face, and hair)

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## AUTHORIZATION FOR RELEASE OF INFORMATION

At Palm Valley Child Development Center, we strive to provide comprehensive care to treat the "whole child." As a part of this effort, we desire to coordinate care with other professionals treating our students. If you authorize Palm Child Development Center to communicate with outside providers regarding your child's care, please complete the following.

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ (Client or Legal Guardian), hereby authorize \_\_\_\_\_

to  send and/or  receive information (as noted below)  to and/or  from

Name of Person or Facility: **Palm Valley Child Development Center**

Phone: **904-373-0743** Address: **185 Landrum Lane** City: **Ponte Vedra Beach** State: Florida Zip Code: **32082**

_____ Academic Testing Results	_____ Psychological Testing Results
_____ Behavior Programs	_____ Service Plans
_____ Progress Notes	_____ Summary Reports
_____ Cognitive Testing Results	_____ Vocational Testing Results
_____ Academic Testing Results	_____ Psychological Testing Results
_____ Medical Records	_____ School Records
_____ Personality Profiles	_____ Entire Record (*except psychotherapy notes)
_____ Psychological Reports	

\*Psychotherapy notes have increased protection under HIPAA, a separate authorization is required

The above information will be used for the following purposes: Planning appropriate treatment or program

- \_\_\_\_\_ Continuing appropriate treatment or program
- \_\_\_\_\_ Determining eligibility for benefits or program
- \_\_\_\_\_ Case review
- \_\_\_\_\_ Updating files

I understand that this information may be protected by title 42 (Code of Federal Rules of Privacy or Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality or Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke the consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Patient Signature (if over 18 years or emancipated): \_\_\_\_\_ Date: \_\_\_\_\_

For Minors:

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## TRANSPORTATION CONSENT FORM

My child, \_\_\_\_\_, has my permission to participate in transportation to and from campus. I agree to release and discharge Collage Day School, its agents, managers, members, or employees from liability growing out of personal injuries and property damage resulting or occurring during the transportation or in transit to and from programs. I acknowledge our child is in good physical health and these do not pose a health hazard to my child. I hereby grant permission and give my/our consent for my child to:

- Be treated by any qualified nurse, physician, or surgeon as may be deemed necessary by Collage Day School or, its agents, managers, members, or employees during the trips;
- Be administered medication and/or emergency first aid care as may be necessary or appropriate;
- Receive treatment in hospitals, medical offices, or elsewhere in the event of accident or illness. To assist in that medical care or treatment, I represent that the medical information supplied on the Emergency Contact Information Form, Medication Treatment Plan Form, and Medical Procedures Treatment Plan Form (the "Medical Forms"), previously submitted to Collage Day School and Mandala Family Wellness is true and accurate. In the event of an injury requiring medical attention, I understand and agree that neither Collage Day School nor its agents, managers, members, or employees are responsible for obtaining, or for the result of any medical or emergency treatment rendered or supplied to my child.

I will hold Collage Day School, and its agents, managers, members, or employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of or the lack of medical or emergency treatment rendered to my child. If the child requires medication during the program, and or there is information of which Collage Day School should be aware, I understand I am required to complete the Medical Forms referenced above and provide the medication to the personnel trained to administer the medication. In the event that a child must be transported to and from programs, I agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

I understand that my child's participation in the activity is a privilege, and not a right. I acknowledge that all school policies and procedures, and understand that all school rules and policies apply to my child during the course of the field trip.

**By signing this form, I hereby release Collage Day School, as well as its directors, officers, administrators, employees, volunteers, and other agents from all liability for any and all injuries arising out of my child's participation in the activity.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## **PARTIES AND CELEBRATIONS 2021-2022**

### **OPTION 1:**

My child, \_\_\_\_\_, has permission to participate in all parties and celebrations with NO LIMITATIONS.

### **OPTION 2:**

My child, \_\_\_\_\_, has permission to participate in all parties and celebrations, but I will provide alternate snacks due to my child's food allergies.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_