

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a. and DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting prescription or non-prescription medication be administered to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place form in child's file when medication is no longer required / authorized.

Licensed Child Care Centers: Log the dates and times medication was administered in the center medical log. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent.

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Name – Child

Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		<input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM			

Yes No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication

Parent Initials

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian

Date Signed

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with HFS 45.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers, Day Camps, and certified Day Care Homes to comply with HFS 46.04(6)(a)1., HFS 55.41(4)(a)1. and DWD 55.08(12)(f) respectively. Personally identifiable information gathered on this form will be used only to verify compliance with the above-mentioned rules.

Instructions: The parent / guardian shall complete this form and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current.

Licensed Child Care Centers: If child is under two years of age, CFS-61, Intake for Child Under 2 Years, must also be completed prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip)	Telephone Number	Birthdate (mm/dd/yyyy)	First Day of Attendance
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PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.
Mother					
Father					
Guardian					
Guardian					

PERSONS OTHER THAN PARENTS / GUARDIANS WHO ARE AUTHORIZED TO PICK UP CHILD – Provide information requested for each person. If no one, write "None."

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

EMERGENCY CONTACT – Provide information for the person to contact when parents / guardians cannot be reached.

Yes No This person is authorized to pick up the child.

Relationship to Child	Name	Address – Home (Street, City, State, Zip)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address	Telephone Number
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AUTHORIZATION

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in field trips and other activities during operating hours. Transported Walking
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian

Date Signed

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is mandatory to comply with HFS 45.07(6)(L)3. and HFS 46.07(6)(k)3. It also meets the requirements of DWD 55.08(4). Failure to comply may result in issuance of a noncompliance statement. Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules.

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months after admission. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years after admission.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)

Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify.

Date of most recent blood lead test (Medicaid policy requires testing at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented): _____ (mm/dd/yyyy)

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)

Address – (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider

Date of Examination

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 **IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR**

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

- For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

- For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian

Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

- Check any special medical condition that your child may have.

<input type="checkbox"/> No specific medical condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / seizure disorder	<input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
<input type="checkbox"/> Cerebral palsy / motor disorder		
<input type="checkbox"/> Other condition(s) requiring special care – Specify.		

 Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
 Food allergies – Specify food(s).

 Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with HFS 45.09(1)(c)1. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of HFS 46.09(1)(a). This form collects information about children under age 2 in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personally identifiable information is collected to assist in providing quality child care services and will be used only for this purpose.

Instructions: This form is to be completed by a parent prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)

Nickname (If any)

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH Note: Health conditions that may affect the care of the child must be recorded on the CFS-2345, Health History and Emergency Care Plan. The CFS-2345 should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule

Length of time on current schedule

Food type

Formula Strained Junior Table Milk type – Specify:

New food timetable

When eating, child is –

Held in lap In highchair Other – Specify:

Feeds self

Yes No If "Yes", uses: Spoon Fork Hands

Special feeding problems

Yes No If "Yes" – Specify:

Food allergies

Yes No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule

Length of time on current schedule

Falls asleep easily

 Yes No

Mood upon awakening – Describe.

Takes favorite toy(s) to bed – **child over age 1 year** Yes No If "Yes" – list toy(s):Sleep position – **child under age 1 year****Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. See HFS 45.09(2)(c) and HFS 46.09(2)(bm). Back for children under age 1 year Side or stomach (physician statement attached)Sleep position – **child over age 1 year** Back Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type

 Cloth Disposable

Diapers provided by parent

 Yes No

Plastic pants used

 Always Never Sometimes If "Sometimes" – Specify:

Highly sensitive skin

 Yes No

Frequent diaper rash

 Yes No

Oil, powder or lotion used

 Yes No If "Yes", product name(s) – Specify:

Toilet training attempted

 Yes No If "Yes", describe routine.

Type of toilet seat used at home

 Potty chair Special toilet seat Regular toilet seat

Regular bowel movements

 Yes No How often.

Time(s) of day:

Toileting problems

 Yes No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family speaks what language – Specify.

 English Other If "Other" – Specify:

Age child began talking

Child speaks in

 Words Sentences

Words used to describe special needs – Specify.

UPDATES

COMFORTING

Does child have a fussy time?

Yes No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

Held Sung to Rocked Read to Other – Specify:

Special things you say or do to comfort child.

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

Sit up alone Pull up Crawl Walk holding on Walk without support

Yes No Is your child used to playmates?

Comments

MISCELLANEOUS

Child's **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite toys and activities – Specify.

UPDATES

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

SIGNATURE – Parent

Date Signed

Homestead Day Care, LLC
Parent - Provider Agreement

29200B Evergreen Drive
Waterford, WI 53185
262-534-3785

Child(ren) Name: _____

Date of Birth: _____

Parent/Guardian #1 Name: _____ Phone Number: _____

Parent/Guardian #2 Name: _____ Phone Number: _____

Enrollment Begin Date: _____

Children's Health Insurance Company: _____

Group #: _____ ID#: _____

Full Time: _____ Part Time: _____

Authorized Attendance Hours

Attendance outside these hours will incur additional charges and must be pre-approved by the Director

Day	Arrival	Departure
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Weekly Tuition - Due the Friday before the week of care:

Name: _____ Rate: _____

Name: _____ Rate: _____

Name: _____ Rate: _____

Multiple Child Discount: _____ Rate: _____

Total Weekly Tuition: \$ _____

I have received the Parent Policy Book and agree to all policies and procedures, including the two-week paid notice to terminate my child care contract. I understand the Registration Fee and first (1st) week's tuition must be paid to secure my child's spot in the Program. If my child does not attend the Program, this money is forfeited. I understand that I (we) are solely responsible for payment, even if payment is supplemented by another party.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

SCHEDULE OF FEES

(May 03, 2011)

- A. New Enrollment Fee\$40.00
- B. Annual Registration Fee - due January 1st\$40.00
- C. Supply Fee – due July 1st\$35.00
- D. New Infant/New Child Holding Fee – 1 full week Rate per month held.**
This does not apply to the first week of care and is non-refundable.

Weekly Full Time (5 Days Per Week)	
Under 2 Years Old	\$215.00
Over 2 Years Old	\$195.00
Over 3 Years Old	\$180.00
Over 4 Years Old	\$165.00
Sibling Discount Full Time and Part Time – Highest Fee Full Price, Lowest fee 10% Discount, Subsequent Fees 5% Discount. Discount based on regular daily fee before any additional fees. Discount does not apply to School Age Programs.	

Additional Fees:

- Pre-approved Early Drop off/Late Pick Up (Exceeding Contract Times).....\$5.00 per hour
- Unapproved Early Drop Off/Late Pick Up\$10.00 first 15 Minutes
- After 15 Minutes Late\$5.00 per minute
- Late Payment\$10.00 per day
- No Call-No Show\$20.00 per occurrence
- Admin Fee for Subsidized Payments\$10.00 per month

Daily Part-Time (1 to 4 Contracted Days Per Week)	
<u>Full Day – Over 5 Hours</u>	
Under 2 Years Old	\$46.00
Two (2) Years Old	\$41.00
Three (3) Years Old	\$39.00
Four (4) Years Old	\$35.00
Varied Days for All Ages (Not a specific or set contracted day or changes weekly)	\$5.00 additional per day
<u>Half Day (5 Hours or Less)</u>	
Under 2 Years Old	\$36.00
Two (2) and Three (3) Years Old	\$31.00
Four (4) Years Old	\$29.00
Varied Days for All Ages (Not a specific or set contracted day or changes weekly)	\$5.00 additional per day

Absence Due To Paternity/Family Leave – Holding Fee

- First 4 Weeks - 1 Full Week Rate Per Child
- After 4 Weeks – Normal Fees

Vacation, Illness & Holidays – See Fee and Refund Policy

Miscellaneous Fees

- | | |
|---|---------------------------------------|
| NSF Check\$20.00 per check returned | Diaper\$2.00 |
| Infant’s Food per Jar..... \$1.00 | Box of Wipes\$3.00 |
| | In-House Field TripsOpen |

Homestead Day Care
29200B Evergreen Drive
Waterford, WI. 53185
262-534-3785

Date: _____

Please send

Label All Items including Food and Bottles

Boxed Wipes

Diapers

Ointment (if needed)

Onesies

Nuks - 2 - if used

Blanket for crib (washed weekly)

Prefilled Bottles

Formula Dial - if used - for pre-measured bottles

Muck Luck Shoes

Jar Food

Extra Change of Clothes

Clothing for Outdoor Weather

Sleeping Buddy

Sleeping Bag

Slippers

Pants

Socks

Jacket

Shorts

Undershirt

Sweater

Long Sleeved Shirt

Sweat Shirt

Tie Shoes

Boots

Hat

Mittens



Thank You



Homestead Day Care, LLC
29200B Evergreen Drive
Waterford, WI, 53185
262-534-3785

ALLERGY REMINDER

Just a quick reminder to everyone that we do have a *peanut allergy* in our daycare. As much as we love all your treats, please **do not** bring any treats that have any kind of nut, peanut or peanut butter. Always remember to check ingredient labels on packages before bringing them into the daycare.

Even if you know the product does not contain any nuts, still check the label. Sometimes different products are made in the same machines causing traces of nuts or their oils to be in another product. In this case, many packages will have a special note concerning allergies. If not, please take a minute to read through the ingredients and make sure there are no nuts.

Also, always leave all labels on store-purchased foods. We always double check our food labels before serving the food.

The allergic reaction caused by nuts can be very serious. So please check all labels carefully before bringing in treats.

Thank You,

“The Homestead Gang”

Homestead Day Care, LLC
29200B Evergreen Drive
Waterford, WI, 53185
262-534-3785

NO CARS WILL BE LEFT RUNNING IN PARKING LOT!

The State of Wisconsin has ruled that it is a hazard to children when cars are left running while children are dropped off and picked up in **winter and summer**. We are informing you of this in writing and will post it as well. We agree with this ruling and **will enforce** it as necessary. Please follow this ruling.

Thank you very much,

Homestead Day Care Staff

Homestead Day Care, LLC
29200B Evergreen Drive
Waterford, WI, 53185
262-534-3785

I give permission to Homestead Day Care, LLC, to post pictures

only taken of my child(ren)_____

_____ while at Homestead Day
Care on their website or in newspaper articles. No names will be
posted on the website.

Parent/Guardian Signature

Date

Printed Name

Thank you!