Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Dear Parents,

Please take a moment to look over all the information provided to you in this packet. We understand that there are a lot of forms to fill out and this can be time consuming. However, you must have every form in this packet completed and turned into the Registrar office. The forms in this packet include the following:

- **Admission Information**: Please sign all areas on this form where it is indicated. Each item is very important and either provides you with information from us or provides us with information about you and your child. Please provide name, **complete address**, and telephone number for the emergency contact persons in the area provided on the form. **If something is not applicable for your child just put N/A.**
- **Parent Handbook** can be found at **http://moodychildhoodcenter.org/en/resources/parent-portal-info**
- **Operational Discipline and Guidance Policy**
- **Operational Policy on Infant Safe Sleep**
- **Child Health for Child Care at Moody Early Childhood Center**: a medical statement signed by an approved health professional is **required** of all children stating that the child is able to participate in the program. This medical statement must be submitted to the office upon admission (see form).
- **Physician's Diet Modifications/Allergies/Disabilities and FARE (Food Allergy & Anaphylaxis Emergency Care Plan):** These forms must be completed by medical provider if your child has any allergies and/or disability. If your child has an allergy or food preference, please provide complete information including symptoms to watch for, if emergency medication (i.e. EpiPen) has been provided.
- **Child Assessment Form**
- **CACFP Enrollment Forms**
- Supply List
- **Tuition and Payment Information**
- **Teen Health Clinic Form**

You must also provide the following documents:

1. A copy of your child's **current** immunization record
2. Child's Birth Certificate
3. Parent/ Guardian Photo Identification
4. Proof of Residency

Thank you so much for providing these forms to us. It will be your responsibility to keep us informed of changes to your information as it occurs. ***Change of Information forms are available at the front office***. If you have any questions about the packet provided to you just give us a call. Again, thank you for choosing Moody Early Childhood Center.

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

ADMISSION INFORMATION

NOTE: THIS ENTIRE FORM MUST BE UPDATED SEMI-ANNUALLY

Child's Legal Last Name:	
Child's Legal First Name:	
Child's Legal Middle Name:	
Date of Birth	
Gender	☐ Male ☐ Female
Ethnicity (MUST – check one): ☐ Hispanic ☐ Non-Hispanic	Race (MUST – Check One or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
Child Lives With	☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian Custody Documents on File: _____
Child's Home Address	
Name of Parent of Guardian Completing Form	

Karin Miller
Executive Director
1110 21st Street
Galveston, Texas 77550

For MECC Use Only

Entry Date _____

Withdrawal Date_____

Tuition _____

Parent/Guardian 1:	**Parent/Guardian 2:**
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Employer/School:	Employer/School:
Employer/School Address:	Employer/School Address:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Authorized to Pick-Up Child: YES NO	Authorized to Pick-Up Child: YES NO

AUTHORIZATION FOR RELEASE

Authorized Person other than a parent to whom the child may be released:

1. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
2. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
3. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
4. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____

EMERGENCY CONTACTS

When parents cannot be reached, list at least two people who may be contacted in case of an *emergency* (address must be provided):

1. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
2. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
3. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
4. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:	School Phone Number:
My child has permission to (check all that apply): ☐ Walk to or from school or home ☐ ride the bus ☐ be released to the care of his/her sibling under 18 years old	
Authorized pick up/drop off locations other than the child's address:	
Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

Check ALL that apply:

I acknowledge that I have read and understand the facility's Operational Policies/Parent Handbook found at http://moodychildhoodcenter.org/en/resources/parent-portal-info.

☐ Discipline and guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medication
☐ Procedures for conducting health checks	☐ Immunization requirement for children
☐ Safe sleep	☐ Meals and food service practices
☐ Procedures for parent 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, DFPS, Child Abuse Hotline, and DFPS website
Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

MEALS

I understand that the following meals will be served to my child while in care:

☐ Breakfast	☐ Morning Snack	☐ Lunch
☐ Afternoon Snack	☐ Supper	☐ Evening Snack
☐ None		

DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

Child's Name:

Check ALL that apply:

1. Transportation

I give consent for my child to be transported and supervised by operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ 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 trip

Comments:

3. Water Activities

I give consent for my child to participate in the following water activities:

☐ water table play ☐ on sprinkler play ☐ splashing/wading pools ☐ aquatic playgrounds

4. I ☐ give ☐ do not give Moody Early Childhood Center permission for my child to receive all necessary health and developmental screenings, assessments and laboratory tests required by the program. These may be performed by MECC and GISD staff.

5. I understand that Mental Health professionals will be making routine Mental Health observations at MECC. I hereby ☐ give ☐ do not give my permission for the Mental Health professional to review my child's records and to advise on behavior issues.

6. I ☐ do ☐ do not understand that my child may receive a dental and medical examination and that I will accompany my child for these exams if at all possible. I will receive information on results and needed follow-up.

7. I ☐ give ☐ do not give my authorization for my child's Developmental Screening, Assessment and Summary of Services to be transferred to the public school, if requested by either parent or school.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signature of Parent/Guardian **Date**

PERMISSION TO PHOTOGRAPH

I, _____, give permission for Moody Early Childhood Center to photograph/take video of my child, _____, for the following purposes:

Type of Use:	**(Please check one)**	
	Grant Permission	**Decline Permission**
Photographs:		
Display photos in the child's classroom		
Display photos on bulletin boards outside classroom		
Display photos in center's scrapbook		
Display photos on center's bulletin boards, shown to current and prospective students		
Display photos on center's website *		
Display photos on center's Facebook page *		
Use photos in promotional materials		
Videos:		
Give video to current parents		
Display video on program website		
Use videos in promotional materials		
Other (please list):		

** No names of students will be displayed on the facility website, in social media, or video. First names with last initial may be displayed throughout the center to identify student's personal items and work.*

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

Signature of Parent/Guardian **Date**

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:

If no special needs write **NONE**.

Does your child have diagnosed food allergies? ☐ Yes ☐ No

If yes, GISD Physician's Diet Modifications and FARE – Food Allergy & Anaphylaxis Emergency Care Plan must be completed by child's physician and turned in prior to admission.)

FARE Submitted on

GISD Physician's Diet Modification Submitted on

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 of Legal Guardian	Date Signed:

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 of Legal Guardian Date Signed

ADMISSION REQUIREMENT

Child's Name: _____

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.

Health Care Professional's Signature:	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 of Health Care Professional	Address of Health Care Professional
Signature — Parent or Legal Guardian	Date Signed

A medical statement signed by an approved health professional is required of all children.

A copy of child's current immunization record must be provided upon admission

ANNUAL UPDATE: Make necessary changes & sign & date below to verify that the information is current.

Child's Name: _____

Parent/Guardian Signature:	**Date:**
Parent/Guardian Signature:	Date:
Parent/Guardian Signature:	Date:
Parent/Guardian Signature:	Date:

Texas Department of
Family and Protective Services

Form J-800-1099
New January 2018

OPERATIONAL DISCIPLINE AND GUIDANCE POLICY

Purpose: This form provides the required information per minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

DISCIPLINE AND GUIDANCE POLICY

Discipline must be:

1) Individualized and consistent for each child;
2) Appropriate to the child's level of understanding; and
3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
2) Reminding a child of behavior expectations daily by using clear, positive statements;
3) Redirecting behavior using positive statements; and
4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

1) Corporal punishment or threats of corporal punishment;
2) Punishment associated with food, naps, or toilet training;
3) Pinching, shaking, or biting a child;
4) Hitting a child with a hand or instrument;
5) Putting anything in or on a child's mouth;
6) Humiliating, ridiculing, rejecting, or yelling at a child;
7) Subjecting a child to harsh, abusive, or profane language;
8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

ADDITIONAL DISCIPLINE AND GUIDANCE MEASURES (ONLY APPLIES TO BAP/SAP PROGRAMS THAT OPERATE UNDER CHAPTER 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

SIGNATURE	
This policy is effective on the following date:	
Signed by: X	Role: ☐ Parent ☐ Caregiver/Employee ☐ Household Member (Ch. 747 only)

MINIMUM STANDARDS RELATED TO DISCIPLINE

- Title 40, Chapter 746 Subchapter L:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=746&sch=L&rl=Y
- Title 40, Chapter 747 Subchapter L
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=747&sch=L&rl=Y
- Title 40, Chapter 744 Subchapter G:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=744&sch=G&rl=Y

TEXAS Health and Human Services

Form 2550
April 2019-E

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at Moody Early Childhood Center and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at Moody Early Childhood Center will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415 and §747.2315]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415 and §747.2315].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing_____(insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415 and §747.2315].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2415 and §747.2315].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on (Date)	Child's name

Signature — Director/Owner

Date Signed

Signature — Staff member

Date Signed

Signature — Parent

Date Signed

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

CHILD HEALTH STATEMENT FOR CHILD CARE

AT

MOODY EARLY CHILDHOOD CENTER

(Doctor's office may use their own form or this form)

Doctors may email their form to kris@moodyearlychildhoodcenter.org

or fax to (409) 750-7177

This is to certify that I have examined _____ (print child's name)

on _____ (date), and found him/her to be healthy, free of contagious disease and able to

participate in school/daycare activities.

Health Care Professional Name _____

Health Care Professional Contact Information

_____

_____

_____

Health Care Professional Signature _____

The Moody Early Childhood Center is a private nonprofit 501 (c) (3) and does not discriminate on the basis of sex, race, color, national origin, disability, religion or age in the administration of its educational policies, admissions policies, and all other school-administered programs.

Galveston ISD Child Nutrition Department
409-766-5162 (Fax) 409-766-7040

FAX TO: 409-766-7040 ATTN: Jennifer Douglas

PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name_____ Student Name_____
Campus Name_____ Date of Birth _____
As parent or guardian, I give **permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. _____(Signature)

PART A – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY COMPLETE THIS PART

(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART B on back of page)

PHYSICIAN'S STATEMENT Date _____

I_____**, (physician) declare the child listed above to possess**
Physician's Name (please PRINT)
the following LIFE THREATENING FOOD ALLERGY.

1. Life threatening food allergy – Omit these foods:
____fluid milk ____peanuts ____tree nuts ____eggs ____fish ____shellfish ____wheat ____soy

2. Can the student consume foods where the allergen is an ingredient in the food product? _____yes _____no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
Explain_____

3. Other life threatening food allergies (list all) – Omit these foods:
_____

4. Explanation of why this disability restricts diet: _____

5. Major life activity affected by the life threatening food allergy (check all that apply):
(NOTE: .Galveston cannot honor this document unless at least one life activity is marked.)
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing ____speaking ____breathing ____learning

6. Foods to Substitute *(NOTE: .Galveston ISD cannot honor this document unless substitutions are listed below.)*
_____

_____
Physician's Signature

_____ _____
Telephone Clinic/Facility Name & Address

Galveston ISD Child Nutrition Department
409-766-5162 (Fax) 409-766-7040

FAX TO: 409-766-7040 ATTN: Jennifer Douglas

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals. _____Campus _____

Parent/Guardian Name_____Student Name_____Date of Birth_____
As parent or guardian, **I give permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. _____(Signature)

PART B – STUDENTS WITH DISABILITIES COMPLETE THIS PHYSICIAN'S STATEMENT

Date _____

I_____**, (physician) declare the child listed at top of page to possess**
Physician's Name (please PRINT)
the following DISABILITY.

1. List any disability requiring meal modification: _____

2. Explanation of why this disability restricts diet: _____

3. Major life activity affected by the DISABILITY (check all that apply):
(NOTE: Galveston ISD cannot honor this document unless at least one life activity is marked.)
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing _____speaking ____breathing ____learning ____other, specify_____

4. Foods to Omit:

_____
_____
_____

5. Foods to Substitute *(NOTE: Galveston ISD cannot honor this document unless substitutions are listed below.)*

_____
_____

_____
Physician's Signature

_____ _____
Telephone Clinic/Facility Name & Address

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

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

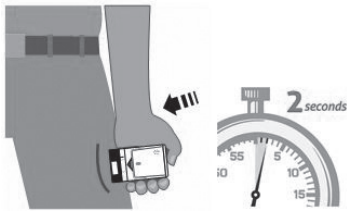
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

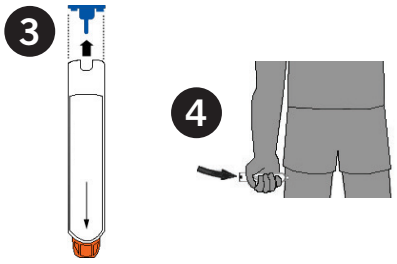
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



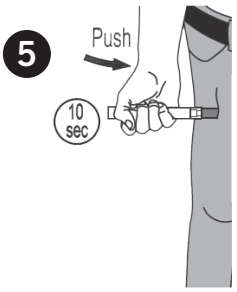
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. 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.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

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) 1/2019

Child Assessment Form

Child Name (last, first, middle)	Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)	City	County	Zip
Mailing Address (if different) -- Street or P.O. Box	City	County	Zip
Telephone No. (include A/C)			

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date Signed

Additional Comments:

CCS-1500

CACFP NEW STUDENT ENROLLMENT FORM

Child Care Center Name: Moody Early Childhood Center Site Code: 1425

INSTRUCTIONS: Complete ALL Fields. Sign and Date form. Submit back to Day Care Director.

Parent's First Name:

Parent's Last Name:

Parent's Phone Number:

Child's First Name:

Child's Last Name:

Child's Birthdate: / /

Special Needs: ☐ YES ☐ NO (Provide Professional Documentation)

Foster Child: ☐ YES ☐ NO (Provide DFPS Form 2085FC)

Head Start / Early Head Start / Even Start: ☐ YES ☐ NO (Provide HSP/ESP/EHSP Documentation)

Ethnic Identity: (*mark only 1*) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Racial Identity: (*mark 1 or more*) ☐ White ☐ Black/African American ☐ Am. Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

Gender: ☐ Male ☐ Female

Child Care Center Enroll Date: / /

Child's Normal Days in Care:
Center's Days of Operation
M-F
☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

Child's Normal Hours in Care:
Center's Hours of Operation
07:00 AM-06:30 PM
: ☐ a.m. ☐ p.m. **TO** : ☐ a.m. ☐ p.m.

Meals/Snackes Child Receives:
Meals/Snacks Served at Center
PM S LUN BRK
☐ BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS

Times Child Attends Public School
(school age children only)
: ☐ a.m. ☐ p.m. **TO** : ☐ a.m. ☐ p.m.

PARENT CERTIFICATION

- *My child may be in care on different days & hours than listed above.* ☐ *Yes* ☐ *No*
- *I certify the information on this form is true and correct to the best of my knowledge.*
- *I certify that I have received access to WIC and CACFP literature within the last 12 months.*

/ /

Signature of Parent/Guardian *Date of Parent/Guardian Signature*

Sponsor Use Only:

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, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. 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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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.

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;

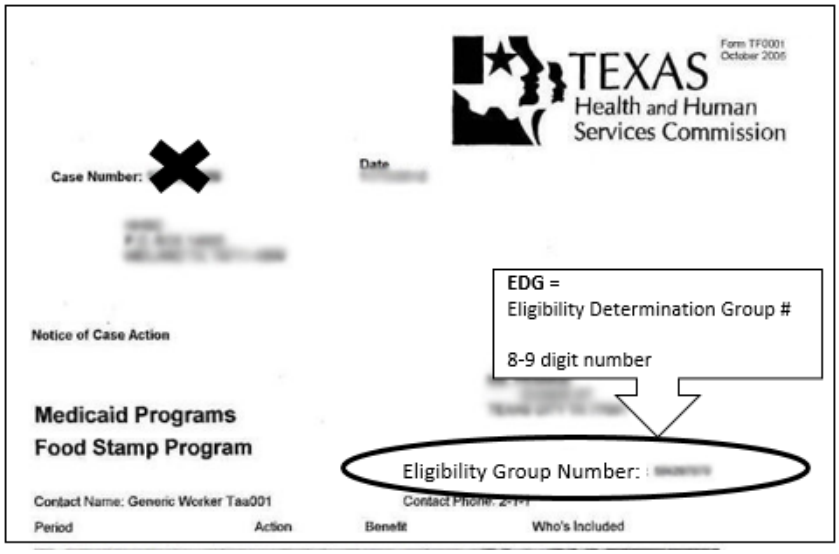
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see illustration).
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.



If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes**. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. See next.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Infant Declaration Form:

Child Care Center Name Moody Early Childhood Center

INSTRUCTIONS TO PARENTS:
Complete BOTH sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ **Birth Date**__/__/____

Parent's Name _____

My Child is allergic to the following foods:
(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

_____ _____

_____ _____

Section 2

Your child care provider offers the following infant formula(s): Various Generic Iron Fortified Infant Formula

Parent Declaration - ***Select only ONE of the following options.***

☐ **Center will provide ALL meal components for infant named above.**

OR

☐ **Parent will provide ALL meal components for infant named above.**

OR

☐ **PARENT and CENTER will provide meal components for infant named above, as indicated below:**

	0-5 Months	6-11 Months
( ) Center OR ( ) Parent will provide Iron Fortified Infant Formula / Breast Milk	( )	( )
( ) Center OR ( ) Parent will provide Iron Fortified Infant Cereal		( )
( ) Center OR ( ) Parent will provide Infant Fruits/Vegetables		( )
( ) Center OR ( ) Parent will provide Infant Meats		( )
( ) Center OR ( ) Parent will provide Crusty Bread/Crackers		( )

***** This form must be updated and submitted any time there is a change in Section 2.**

_____ _____/_____/_____

Parent Signature **Date**

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Supply List for Infant and Toddlers

Infant (0-9 Months)	Toddler (10-12 Months)	Toddler (12-17 Months)	Toddler (18+ Months)
2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes
2 Bottles of Lysol Spray	2 Bottles of Lysol Spray	2 Bottles of Lysol Spray	2 Bottles of Lysol Spray
2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer
2 Boxes of Kleenex	2 Boxes of Kleenex	2 Boxes of Kleenex	2 Boxes of Kleenex
2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed
2 Bottles of Hand Soap	2 Bottles of Hand Soap	2 Bottles of Hand Soap	2 Bottles of Hand Soap
1 Box of Non Latex Gloves	1 Box of Non Latex Gloves	1 Box of Non Latex Gloves	1 Box of Non Latex Gloves
Diapers	Diapers	Diapers/Pull-Ups	Diapers/Pull-Ups
Bottles	Sippy Cups	Sippy Cups	Sippy Cups
Full Change of Clothes	Full Change of Clothes	Full Change of Clothes	Full Change of Clothes
Formula/Distilled Water	Bibs	Any Personal Items	Any Personal Items
Bibs	Any Personal Items		
Baby Food/Utensils			
Pacifiers			
Any Personal Items			
All –in- All PJ's			

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Tuition and Payment Information

- 6 weeks to 23 months $195 a week or $780 a month
- 24 months to 3+ $165 a week or $660 a month
- After School PK3 or PK4 $65 a week or $260 a month
- Pre-K 3 $150 a week or $600 a month
- Holidays PK3 or PK 4 $150 a week

MECC will offer a 25% discount for siblings. The 25% reduction will be taken from the tuition of the oldest child attending.

Payments may be made on a weekly or monthly basis. Payment must be received by 5:00 p.m. on the Friday before care is provided. There will be a $20/day late fee assessed.

We accept money orders, cashier's checks, debit and credit card payments. We are unable to accept personal checks.

Financial Assistance

For those families requesting financial assistance, the Moody Early Childhood Center, will be collaborating with Gulf Coast Workforce Solutions. To see if you meet eligibility requirements, go to http://www.wrksolutions.com/for-individuals/financial-aid/financial-aid-for-child-care . You must download an application, and submit all necessary documentation in order to qualify. Applications can be found at http://www.wrksolutions.com/for-individuals/financial-aid/how-to-apply-for-financial-aid.

To be eligible for MECC financial assistance, you must:

- Complete and submit a Financial Aid/Services application through Workforce Solutions.
- Be approved for assistance and placed on the Gulf Coast Workforce Solution waiting list
- Pay your child's temporary tuition rate of $40/week until three (3) months review or until funding is available.
- Meet weekly with your designated MECC family advocate.

Please understand your tuition rate may increase or decrease once your receive subsidy.

Any questions please call (409) 761-6930.

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Tuition/Payment Information	
Child's Name	
Child's Date of Birth	
Enrollment Date	
Person responsible for payment of tuition and fees	
Name	
Address	
Phone	
Email	
Type of Payment	☐ **Weekly** ☐ **Monthly**
Effective Date	

The Moody Early Childhood Center is a private nonprofit 501 (c) (3) and does not discriminate on the basis of sex, race, color, national origin, disability, religion or age in the administration of its educational policies, admissions policies, and all other school-administered programs.

Teen Health Center, Inc.

PATIENT INFORMATION

Name: _____
(first) (middle) (last)

Date of Birth: _____ Sex: ☐ Male ☐ Female
(month/day/year)

Address: _____
(street) (city) (state) (zip code)

School: Moody Early Childhood Center Grade: ☐ Daycare ☐ Preschool ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Other _____

Who is the patient's regular doctor? _____
(name) (office telephone)

PARENT/ GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/ Legal Guardian: _____
(first) (last)

Parent/ Legal Guardian: _____
(first) (last)

Contact Information for Parent/ Guardian (Important!! Please provide as much information as possible so we will be able to contact you)

Telephone: _____
(home) (work) (mobile)

Email: _____

Additional Emergency Contact: _____
(name) (relationship to patient)

Telephone: _____
(home) (work) (mobile)

P.O. Box 925, Galveston, TX 77553 www.teenhealthcenter.org Fax: 409-765-5026

INSURANCE INFORMATION

Does your child have:

☐ Private insurance _____
(company) (coverage number)

☐ Medicaid _____
(Medicaid number)

☐ Child Health Insurance Plan _____
(CHIP number)

MEDICAL HISTORY

Does your child take any medications on a regular basis? ☐ No ☐ Yes (please provide the name of the medication and the reason it is given) _____

Does your child have any allergies to medicine? ☐ No ☐ Yes (if "yes", please provide the name of the medication and type of reaction) _____

Does your child have allergies, sensitivities, or reactions to any substances such as food, mold, pollen, animal dander, dust or insects?	☐ No ☐ Yes
Does your child have asthma?	☐ No ☐ Yes
Has your child ever had a seizure?	☐ No ☐ Yes
Does your child have diabetes?	☐ No ☐ Yes
Does your child have a heart condition?	☐ No ☐ Yes
Has your child ever had to stay overnight in the hospital?	☐ No ☐ Yes
Has your child ever had surgery?	☐ No ☐ Yes
Has your child suffered from severe trauma or severe injury?	☐ No ☐ Yes
Has your child had any mental health or behavioral issues?	☐ No ☐ Yes
Does your child have any other health problems?	☐ No ☐ Yes

Please explain any "yes" responses: _____

P.O. Box 925, Galveston, TX 77553 www.teenhealthcenter.org Fax: 409-765-5026

FAMILY HEALTH

Does any family member have Tuberculosis (TB)? ☐ No ☐ Yes

Does anyone smoke in the home? ☐ No ☐ Yes

Please explain any "yes" responses: _____

AUTHORIZATION FOR SPECIFIC HEALTH CARE SERVICES

Please complete by circling MAY OR MAY NOT on all three of the next statements:

1. My child **MAY** or **MAY NOT** receive care for medical illnesses or injuries. I understand that a parent or guardian may not always be present for the visit if a concern arises during the school day. *

2. My child **MAY** or **MAY NOT** receive routine physical exams, hearing and vision screening, and developmental screening. I understand that a parent or guardian may not always be present. *

3. My child **MAY** or **MAY NOT** receive age appropriate health and nutrition education from a Teen Health employee.

*You will be notified of any care provided either by telephone or in writing.

PARENTAL PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed above. My signature provides permission for my child to receive the services I have circled above from the Teen Health Center. Teen Health Center works collaboratively with teaching hospitals and Universities. There may be times when medical students, residents, or graduate students participate in patient care. The same HIPAA policies apply to these providers and confidentiality will be maintained. I understand that I can change my mind later on and decide I do not want my child to receive services from the Teen Health Center. If I change my mind, I will let the Teen Health Center know in writing. I understand that this permission form remains valid until the Teen Health Center receives a written revocation from me. NOTE: By law, parental consent is not required for urgent/emergent first aid treatment and the provision of services where the health of the patient appears to be endangered.

In the event of an emergency situation, I realize it may be necessary for the Teen Health Center, Inc to release my child's health information to the Moody Early Childhood Center administration. This sharing of information is needed to protect my child's health and safety. I also realize that the Teen Health Center may share information with the school nurse to ensure that my child's vaccines are up to date. Separate authorization is required for sharing additional health information. I understand this information will remain confidential in accordance with federal and state laws.

My signature also indicates that I am aware that my child's health information may be released as indicated above and that I have been given the opportunity to review the Notice of Privacy Practices.

X _____

(signature of parent/legal guardian) (date)

☐ Check box if you do not want to receive information via email or mail from the Teen Health Center, Inc.

P.O. Box 925, Galveston, TX 77553 www.teenhealthcenter.org Fax: 409-765-5026