Crosby Christian Academy

Rate Sheet 2016 - 2017

Age Group	Program	Weekly	1st & 15th	1st Monthly
Early Childhood				
Infants - 0yr	Full Time	$175.00	$380.00	$700.00
Infants - 1yr	Full Time	$165.00	$358.00	$660.00
Toddlers - 2yrs	Full Time	$155.00	$335.00	$620.00
Pre-School - 3yrs	Full Time	$145.00	$314.00	$580.00
Pre-School - 4yrs	Full Time	$140.00	$303.00	$560.00
Pre-School - Mornings	8:00 -11:30	$70.00	$151.00	$280.00
School Age				
K - 6th	Before & After	$90.00	$195.00	$360.00
K - 6th	Before Only	$50.00	$108.00	$200.00
K - 6th	After Only	$75.00	$163.00	$300.00
1st -6th Summer Camp	Full Time	$130.00	$281.00	$520.00

Conditional Fees			
Field Trip shirts	$16	Weekly Tuition Late Fee	$25
Hearing & Vision Test	$15	Family Registration	$75
Extra Door Fob's	$10	(Sept 1st) Annual Family Fee	$50
Extra Door Cards	$5	Return Check Fee	$25
MMA Belt Test	$25	MMA Uniform	$35
Cap & Tassle	$10	School age Drop In	$30

Texas Dept of Family and Protective Services

ADMISSION INFORMATION

Form 2935
Aug 2010 / Pg 1 of 3

Operation Name	Director's Name	
Crosby Christian Academy / CCA Kids	Rivers Bowden	
Child's Full Name	Child's Date of Birth	Child's Home Telephone No.
Child's Home Address		
Date of Admission / Date of Withdrawal		
Parent's or Guardian's Name	Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached: | Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

☐ to and from home

Walk home ☐ for emergency care ☐ on field trips ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES:

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ None ☒ Breakfast ☒ AM Snack ☒ Lunch ☒ PM Snack ☐ Supper ☐ Evening Snack

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☒ Mondays	from: 6:00	to: 6:30
☒ Tuesdays	from: 6:00	to: 6:30
☒ Wednesdays	from: 6:00	to: 6:30
☒ Thursdays	from: 6:00	to: 6:30
☒ Fridays	from: 6:00	to: 6:30
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

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:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____
Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, 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 caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to: ☐ walk to or from school or home, ☐ ride a bus, and/or ☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

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

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please 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 / she is able to take part in the day care program.

_____ _____
Health Care Professional's Signature Date

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 will submit it to the child-care operation.

Name and address of health care professional:

_____ _____
Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:	Date of Birth:

Age ▶ Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)	☐ Positive	☐ Negative	Date:

Signature or stamp of a physician or public health personnel verifying immunization information above.

_____ _____
Signature Date

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

_____ _____
Parent's signature Date

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at
www.dshs.state.tx.us/immunize/public.shtm

_____ _____
Signature – Parent or Legal Guardian Date

Discipline and Guidance Policy for ___Crosby Christian Academy_

- 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; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

_____ _____
Signature Date

Check one please:

☐ parent ☐ employee/caregiver ☐ household member of child-care home

Crosby Christian Academy

Financial Agreement Contract

Payment Plans

☐ **Weekly** plans are due each Friday in advance.
☐ **Twice Monthly** Plans are due on the 1st and 15th.
☐ **Bi-weekly** plans are due every other Friday in advance.
☐ **Monthly** plans are due on the 1st of each month.

(Please Check One)

I agree to pay a tuition fee of $_____ for my child(ren).

The Email Address(s) your statements will be sent to:

_____@_____

_____@_____

Tuition Late Fees

Weekly invoices are posted on Fridays for the coming week. A five day grace period is given on all plans. If payment is not received by the fifth day a $25.00 late fee will charged to your account weekly.

Student Handbook Acknowledgment

Upon enrollment you received a copy of the Crosby Christian Academy Student Handbook

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I have read and understand the Crosby Christian Academy tuition and tuition late fees policy.

I hereby acknowledge and agree to abide by the policies and requirements stated in the Crosby Christian Academy Student Policy Handbook 2017.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Date_____

MEDICAL STATEMENT FOR
FOOD ALLERIGIES AND/ OR INTOLERANCE(S)

1. School/ Agency Name	2. Site Name	3. Site Telephone Number
4. Child's Name		5. Date of Birth:
6. Name of Parent of Guardian		7. Telephone Number

8. Check one:

___Participant has a disability or a medical condition and *requires* a special meal or accommodation.
A licensed must sign this form.

___Participant does not have a disability. But is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. A licensed physician must sign this form.

9. Disabiltiy or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation-use extra pages as needed)

12. Indicate Texture:

___Regular ___Chopped ___Ground ___Pureed

13. Foods to be omitted and substitutions: Please list specific foods to be omitted and suggested substitutions.

You may attach a sheet with additional information as needed

A. Foods to be Omitted	B. Suggested Substitutions

14. Adaptive Equipment:

15. Signature of Parent or Guardian	16. Print Name	17. Telephone Number	18. Date
19. Signature of Physician	20. Printed Name	21.Telephone Number	22. Date

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/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/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

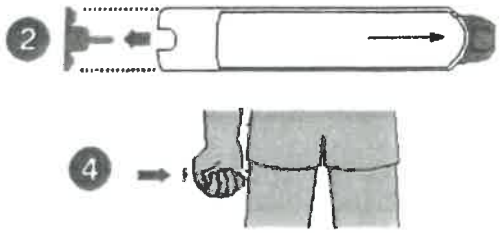
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

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: _____

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