Lamb of God Lutheran Early Childhood Center
1400 FM 1960 East Bypass
Humble, Texas 77338
Phone: (281) 446-5262

2020/2021 Registration & Tuition Rates

Preschool Full -Time (weekly tuition)

Annual Registration Fees (per student) - $160.00

Infants	6:30am – 6:00pm (5 Day Program)	Full Care	$255.00
Toddler	6:30am – 6:00pm (5 Day Program)	Full Care	$250.00
	8:30am – 3:00pm (5 Day Program)	Preschool Only	$200.00
	6:30am – 6:00pm (3 Day Program)		$175.00
Twos	6:30am – 6:00pm (5 Day Program)	Full Care	$23500
	8:30am – 3:00pm (5 Day Program)	Preschool Only	$195.00
	6:30am – 6:00pm (3 Day Program)		$170.00
	8:30am – 3:00pm (3 Day Program)	Preschool Only	$140.00
Threes	6:30am – 6:00pm (5 Day Program)	Full Care	$225.00
	8:30am – 3:00pm (5 Day Program)	Preschool Only	$180.00
	6:30am – 6:00pm (3 Day Program)		$155.00
	8:30am – 3:00pm (3 Day Program)	Preschool Only	$135.00
Fours	6:30am – 6:00pm (5 Day Program)	Full Care	$215.00
	8:30am – 3:00pm (5 Day Program)	Preschool Only	$175.00
	6:30am – 6:00pm (3 Day Program)		$150.00
	8:30am – 3:00pm (3Day Program)	Preschool Only	$130.00

Preschool Part – Time (monthly tuition)

Annual Registration Fees (per student) - $100.00

Monday, Wednesday, Friday	8:30am – 2:30pm	$300.00
Monday – Friday	8:30am – 2:30pm	$550.00

Lamb of God Lutheran Church & School
Early Childhood Center Registration Form

Admission Date: _______________ **Withdrawal Date:** _______________

Child's Last Name: _________________________ **First Name:**________________________ **Gender: M/F**

Date of Birth: ____________________ **Financial Responsibility:** _________________

Church Home: ____ **Child Baptized? Yes or No**

How did you hear about LOGLS? ____

Father's Name: __________________________________ **E-Mail:** ___________________________

Address: ____ **Home Phone:** (___) _________________

City: __________________________ **Zip:**_____________ **Cell Phone** (____) __________________

Father's Employer:________________________________ **Work Phone** (____) __________________

Mother's Name: __________________________________ **E-Mail:** ___________________________

Address: ____ **Home Phone:** (___) _________________

City: ___________________________ **Zip:**_____________ **Cell Phone** (____) __________________

Mother's Employer:________________________________ **Work Phone** (____) __________________

I hereby authorize my child to leave LOGLS *only* with the following persons other than parents:

Name:___________________________ Telephone:______________ Relationship:_____________
Name:___________________________ Telephone:______________ Relationship:_____________
Name:___________________________ Telephone:______________ Relationship:_____________
Name:___________________________ Telephone:______________ Relationship:_____________

Due to custodial or other reasons, the following persons are never allowed to pick up my child:

Name: __________________________ Relationship: _________________________
Name: __________________________ Relationship: _________________________

I designate the following person to be contacted in the event of an emergency if I cannot be reached:

Name	**Telephone**	**Address**	**Relationship**

_______________________________________ _______________________

Parent's Signature **Date**

Lamb of God Lutheran Church & School
1400 Bypass 1960 East, Humble, TX 77338
281-446-5262 www.lambofgodpreschool.net

LAMB OF GOD LUTHERAN CHURCH & EARLY CHILDHOOD CENTER DEVELOPMENTAL PROFILE

ABOUT YOUR CHILD

Child's Name:________________________________ Nickname:_______________________

Does your child sleep through the night? ____

What times does your child go to bed at night? _______ Get up in the morning? ________

Does your child nap? ________ How long does your child nap normally? _____________

Does your child have any special fears? ____

Does your child have any special needs such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the last 12 months, any medication prescribed for long term continuous use or any other information which caregivers should be aware of? ____

Describe your child's appetite: ____

Child's favorite foods are: ______________________Foods your child dislikes:_______________________

How many hours of TV does your child watch? ____________Favorite shows: ________________________

Do you read to your child regularly? ______________Child's favorite play activities:__________________

DEVELOPMENTAL HISTORY

Has your child ever had any diagnostic testing or been diagnosed with a behavior or learning difficulty or developmental delay? Please describe.

____

____

FAMILY HISTORY

Do both parents live in child's home? _____ If not, with whom does child live?______________

If there are other adults in the home, give relationship to the child ___________________________________

____

Has your child been involved in a group setting before such as Sunday School, playgroups or other programs?____

Child's Brother/Sister's Names & Ages (living with child):____

____

Medical Information Required

Child's Name:________________________________ Birthdate:______________________________

Parent's Name:____

A CHILD WHO APPEARS ILL UPON ARRIVAL WILL NOT BE ADMITTED TO CLASS!

NOTE: The parent should authorize the physician (at the time of registration) to accept a call from Lamb of God Lutheran Church & School's staff for emergency medical care.

ADMISSION REQUIREMENT

One of the following must be presented when your child is admitted to the program. Check to indicate the option you select:

_____ Signed Doctor's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in the program.

_____________________________ _____________________________ __________

Physician's Written Name Physician's Signature Date

OR

_____Parent's Statement: My child has been examined within the past year by a licensed physician and is able to participate in the program. *Within 12 months of admission, I will obtain a healthcare professional's signed statement and will submit it to the child care operation.

____

Name, complete address and phone number of physician

____ ________________

Signature – Parent of Legal Guardian Date

* CURRENT IMMUNIZATION RECORD MUST BE ATTACHED OR EMAILED TO DIRECTOR.

* YOU MUST PROVIDE PROOF OF HEARING/VISION SCREENING FOR CHILDREN AGE 4 AND UP.

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

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: ______________________________

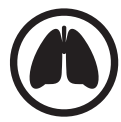
THEREFORE:

[ ] 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:

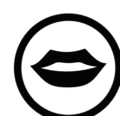
SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

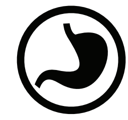
HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

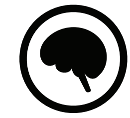


MOUTH
Significant swelling of the tongue or lips

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: [ ] 0.15 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

TREATMENT FOR MINORS CONSENT FORM

Memorial Hermann Northeast Hospital or other:______________________. Please accept this letter as authority to treat my child, in case of emergency, whose name is listed below:

CHILD (Full Name) BIRTHDATE

________________________________ ______________________________

Allergies: Medication____
Food____
Environmental/Other____

Regularly Administered Medications: ____

Child's Doctor ________________________________ Phone (____)_____________
Located at____.
If you are unable to contact him/her, please accept this letter as your authorization to use the doctor on call in the emergency room for any necessary medical treatment.

I/We being the parent(s) or legal guardian(s) of the above named minor do hereby appoint the following individual(s) to act in my/our behalf in authorizing medical, dental, surgical care, and hospitalization for the above named minor in the event I cannot be reached.

Name & Relationship to Child	Address	Phone

Insurance Co:__________________________ **Group #:**___________________

Benefit Verification Phone # (____)_________________

Mother's Employer:_____________________________ Phone (____)_______________
Father's Employer:______________________________ Phone (____)_______________

General Permission & Release:

WATER PLAY

I hereby give my consent for ____________________ (child's name) to participate in the following water activities: (Please initial each activity you give consent for)

_______Water Table/Sprinklers _______Wading Pools _______Splashing Pools

PHOTOGRAPHIC RELEASE

I give my permission to Lamb of God Lutheran Church & School to photograph/videotape my son/daughter ______________________, and use the resulting photographs/videotape for any lawful activities for the purpose of promoting Lamb of God Lutheran School to the public (including but not limited to Facebook, Instagram and our school website). I relinquish all rights, title and interest in the finished photographs, negatives, and videotape film.

Initial - ______ yes _______no Classroom use only ______ yes _______no

MEALS/SNACKS

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

______ Breakfast ______AM Snack ______Lunch ______PM Snack

If I choose to send a snack or lunch for my child, Lamb of God is not responsible for my child's nutritional needs for that meal or snack. Any snack or food sent from home for your child should be nutritious.

MEDICINE RELEASE

The following medications are available at the facility to use if needed. Please initial only the following items that you authorize to be used on your child. Any over the counter medications must have a doctors note to be administered.

________ Diaper Rash Cream

________ First Aid Ointment

________ Insect Repellent

________ Sunscreen

FIELD TRIP/TRANSPORTATION RELEASE

I hereby give consent for my child to attend any In-house field trips which occur during the year here at Lamb of God Church & School Initial-______yes _______no.

MEDICAL (**This must be notarized.**)

In the event that I or my spouse cannot be reached to make arrangements for emergency medical attention, I authorize the person in charge to secure medical help for my child.

Parent Signature:__________________________________

Subscribed and sworn to, before me, this ________ day of _________ 20___.

Notary Public Signature:_________________________

LAMB OF GOD LUTHERAN CHURCH & SCHOOL
Early Childhood Center
EZ-EFT ENROLLMENT FORM

By signing this form you authorize us to draft your child's weekly tuition amount every Friday in advance of services for the upcoming week as well as any other fees incurred.

NAME OF CHILD: ____

Choose One:

☐ **Checking Account Transfer** (Please attach voided check)

☐ **Savings Account Transfer**
Account Number: ______________________________

Routing Number: ______________________________

☐ **Credit Card** (Mastercard or Visa)
Please Note: a 3% service fee will be added to your weekly draft

Visa Card Number: ______________________________ Exp: ____________

Mastercard Number: ______________________________ Exp: ____________

Account Holder Information:
(Note: the information listed below must match the information on the account)

Name: ____

Address: ____

City: ____________________________ State: _______ Zip: _________________

Authorization:

Name of financial institution

I hereby authorize __________________________ to make payment on my behalf from the checking,

savings or credit account listed, and transfer it to **Lamb of God Lutheran Church and School.**

Signature: ___________________________________ Date: _______________________

Lamb of God Lutheran Church &
Early Childhood Center

1400 FM 1960 E. Bypass ◆ Humble, TX 77338
281-446-LAMB (5262)

Tuition Agreement

Child's Name (Please Print): ______________________________ Start Date: ____________________

Registration Fee: ______________________ ❑ Paid OR ❑ Draft _____________________________

Class Assignment: ___________________ Tuition: _________________________________

Tuition Discounts: Member 10% ________________________________

Sibling 5% ________________________________

Full Payment 5% ________________________________

Clergy/Educator/Police/Firefighter/EMT/Military 5% ________________________________

Tuition Fees: Credit Card fee + 3% ________________________________

WEEKLY DRAFT: ________________________________

I have read and agree to adhere to the Registration/Tuition Rates and Policies.

Parent/Guardian Signature: _______________________________

Please Print Student's Name: _______________________________

Date: _______________________________

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: Child Food Program of Texas   Agreement Number: 02141

Facility/Provider Name: Lamb Of God 1040

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: ____________ Date of Birth: ________ Age: ________

Sex: ☐ Male ☐ Female   Date participant enrolled in the facility: ________

Food Allergies: ☐ Yes ☐ No   If "yes" specify: ____________

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** ________ ☐ am ☐ pm **Depart:** ________ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers ____________ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)
whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date ______ Birth - 5 months	Today's Date ______ 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date ______ 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: ____________ Date: ________

Print Name: ____________

Address: ____________ City: ________ State: ____ Zip Code: ________

Home Telephone Number: ____________   Date Dropped: ________

Work Telephone Number: ____________ Emergency Telephone Number: ____________

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA Director Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.

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 case 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