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 non-refundable)

$150.00

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
Twos	6:30am – 6:00pm (5 Day Program)	Full Care	$235.00
	8:30am – 3:00pm (5 Day Program)	Preschool Only	$195.00
Threes	6:30am – 6:00pm (5 Day Program)	Full Care	$225.00
	8:30am– 3:00pm (5 Day Program)	Preschool Only	$180.00
Fours	6:30am – 6:00pm (5 Day Program)	Full Care	$215.00
	8:30am– 3:00pm (5 Day Program)	Preschool Only	$175.00

Preschool Part – Time (monthly tuition)

Annual Registration Fees (per student non-refundable)

$150.00

Monday, Wednesday, Friday	8:30am – 2:30pm	$325.00
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):_____

_____

TEXAS Health and Human Services

Form 2550
October 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 _____ 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 _____ 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(b) and §747.2315(b)]. 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(b) and §747.2315(b)].
- 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(b) and §747.2315(b)].
- 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 [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- 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: _____ Child's name: _____

_____ _____
Signature — Director/Owner | Date Signed

_____ _____
Signature — Staff member | Date Signed

_____ _____
Signature — Parent | Date Signed

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 physicians

_____ _____
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.

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**

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.

SEVERE SYMPTOMS

FOR **ANY** OF THE FOLLOWING:

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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

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 doctor's 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:

I hereby authorize_____ to make payment on my behalf from the checking,
Name of financial institution

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% _____

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: _____