Enrollment Forms

6345 Xerxes Ave S
Richfield, MN 55423
P: (612) 823 - 6822

zoeacademycc@gmail.com | www.zoechildcarecenter.com

WELCOME

Thank you for choosing Zoe Academy as a place for your child to start their early childhood education. We are excited to begin another year with you and your child and we cannot wait to see them grow and flourish! As part of our enrollment process we kindly ask each household to complete the following steps to ensure we have accurate and up to date information on file.

The following process is required for registration to be finalized:

- Tour the facility
- Submit completed application along with the $50 registration fee (non-refundable and non-transferable)
- Submit copy of current Immunization Record from your pediatric physician
- Submit copy of health care summary from your pediatric physician
- Read parent handbook, sign and return all acknowledgements and forms to Admin Coordinator.
- Schedule a “Shadow Day” (students ages 3+) for your child to spend a half-day at the Daycare (9:00a—12:30p)
- Complete & Return Uniform Order Sheet

Please note that all forms must be completed in their entirety and returned to administrative management for your child to start care at Zoe Academy.

CHILD'S INFORMATION

Name: ____ DOB: _____/_____/_____

Age: _________ Sex: M____ F____ Child's SSN: ______-_____-______

Child's Address: ____

City:________________ State:____________ Zip Code:___________

Phone #: (____) ______-______________

Shadow Date: ___/____/____ Expected Start Date: ____/____/____

Enrollment Date: ____/_____/_____ (Actual Start Date) ____/_____/_____

Name of School/Center Child Previously Attended:

____

The following are for demographically statistics only:

Nationality/Race: ________________ Primary language spoken: _______________

Our family is a member at (Church name/location) ___________________________

Religious affiliation _______________________

PARENT'S INFORMATION

Mother: __________________________________ DOB: _____/_____/_______

Home Address: ____

City: ________________ State: ____________ Zip Code: _______________

Home: (____) ______-__________ Cell Phone: (____) ______-__________

Place of Employment: _________________________

Occupation: _________________ Business Phone: (____) ______-__________

Address of Employment: ____

City: ________________ State: ____________ Zip Code: ______________

Email: ____

Father: __________________________________ DOB: _____/_____/_______

Home Address: ____

City: ________________ State: ____________ Zip Code: _______________

Home: (____) ______-__________ Cell Phone: (____) ______-__________

Place of Employment: _________________________

Occupation: _________________ Business Phone: (____) ______-__________

Address of Employment: ____

City: ________________ State: ____________ Zip Code: ______________

Email: ____

HOME INFORMATION

Living Arrangements: Both Parents Mother Only Father Only

Person(s) or Agency that has Custody of Child: ________________________________

Phone #: (____) ______-__________

SIBLINGS NAME	SISTER/BROTHER	AGE

Other Family Members in home: ____
Family Pets: ____

CARE INFORMATION

List anything unusual about your child's development (walking, talking, being able to make wants known, and so forth):

____
____
____

Child's usual bedtime: _______________ Sleeps in a: crib bed co-sleeps
Usually awakens: _______________
Promptly fall asleep: _____yes ______no
Takes daytime nap: _____yes ______no
Is he/she able to take care of his/her bathroom needs? _____yes ______no
For what is your child most often disciplined? __________________________________

____
____

Which type of discipline do you find most effective for your child? ______________

____
____
____
____

Are there any restrictions to play or activities?

____

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.

____

Are there any food restrictions? ____
What's your child's favorite food? ____
What languages are spoken at home? ____

Authorized Pick-Up

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

Please note that the person(s) listed above DO NOT need verbal or written notification to pick up child.

Emergency Contact

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

Name: ____ Birth date: ____/____/____

Physical Address: ____

Relationship to Child: ____________________ Contact Number: ___________________

EMERGENCY CARE INFORMATION

Allergies or Intolerance to Food, Medication or other Special Needs: ___________
____

Child's Physician: ___________________ Phone/Ext: (____) ______-________ _______
Location Address: ____
City: ________________ State: ____________ Zip Code: ________________
Hospital Near Child(ren)'s Home: ____

Child's Dentist : ___________________ Phone/Ext: (____) ______-________ _______
Location Address: ____
City: ________________ State: ____________ Zip Code: ________________

HEALTH INSURANCE INFORMATION

Policy No. ________________________________
Group No: _____________________
Insurance Provider: ____
Insurance Phone No: (____) ______-__________
Name of Policy Holder: ____
Policy Holder's Phone No: ____

MEDICATIONS

Zoe Child Care Center students will not receive any medication unless provided by the parent with a written permission and with specific instructions.

All prescription medication must be in a packaging from the pharmacy with special instructions from the door printed thereto. A medical release form must be completed before Zoe Child Care Center will administer any medicine.

For any medicine to be administered regularly (or for seven (7)-day period), Zoe Child Care Center must have permission and directions form the physician prescribing the medication.

Hospital Treatment Policy

In the event a parent cannot be reached in an emergency, I/we hereby give Zoe Child Care Center official permission to take my/our child to the nearest hospital for treatment while attempting to reach parent. I/we agree to hold such person "harmless and free of any legal responsibility" of any claims, demands, or suit from damages arising from this action.

____________________________________	____________________________________
Parent/Guardian Signature	*Date*
____________________________________	____________________________________
Enrolled Students Name	*Enrolled Students Name*
____________________________________	____________________________________
Zoe Child Care Center Administration	*Date*

AUTHHORIZATION TO DISPENSE EXTERNAL PREPARATIONS

Parental Authorization. Except for aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I ____ (Parent), give Zoe Child Care Center, permission to apply one or more of the following topical ointments/preparations to my child _________________________ in accordance with the directions on the label on the container. I acknowledge that it is recommended that I dress my child appropriately according to the weather. However, I give Zoe Child Care Center permission to remove or add additional layered clothing when needed.

Please place an "x" in the spaces below indicating the items you authorize Zoe Academy to dispense:

_____ Baby Wipes
_____ Band-Aids
_____ Neosporin or similar ointment
_____ Bactine or similar first aid spray
_____ Sunscreen
_____ Insect Repellent
_____ Non-Prescription ointment (such as A & D, Destin, Vaseline)_____ Baby Powder
Other (please specify): ____

____________________________	____________________________
Parent/Guardian Signature	*Date*
____________________________	____________________________
Enrolled Students Name	*Enrolled Students Name*
____________________________	____________________________
Zoe Child Care Center Administration	*Date*

FINANCIAL AGREEMENT FORM

Please initial next to each number in the space provided and sign at the bottom of the document.

1. ______ The registration fee of $50 is due at the time of registration. This fee is non- refundable and non-transferable. This fee must be paid at time of enrollment in order to hold a place in the class.

2. ______ The charge for tuition is a weekly fee. It is not based on a daily or calendar month fee. All payments are due on the 1st day of the week of the provided service. Copayments are due on the 1st day of the current billing cycle. Payments are considered late when received after 6pm on that Monday.

3. ______ Zoe Child Care Center processes tuition payments through Brightwheel. Other payments can be made through cash app, PayPal and onsite. Payments can be made through a card or checks/money orders. Cash payments are discouraged.

4. ______ A $30 Insufficient Fee (NSF FEE) will be charged for failed Automatic Draft attempts and returned checks. A $30 NSF Fee will be charged for all returned checks paid directly to Zoe Child Care Center. If the same check is returned a second time, there will be an additional $25 fee and the check will not be re- deposited. It must be replaced with cash.

5. ______ Late payments will incur a $15 Late Fee.

6. ______ Your account with Zoe Child Care Center is a family account. It is the school's policy that report cards are held and records will be blocked on all overdue accounts. All past due balances for school, preschool tuition, extended care and any other miscellaneous charges must be paid with cash or money order to receive any report cards, transcripts or records as well as end of year tax statements.

7. ______Overdue accounts will result in the student not being permitted to attend special class trips or return to school until the account is made current. Accounts must be current to participate in discount credits.

8. ______ A receipt is always given through Brightwheel when payment is made in cash. Please keep your receipt as a record of your payment.

9. ______ Withdrawal from care requires a written 2-week notice. Even if the child does not attend those two weeks, the parent is responsible for the tuition of those two weeks.

10. ______ I will be responsible for the attached named student's tuition payments and will adhere to the financial policies of Zoe Child Care Center as stated above.

Agreements

1. Zoe Child Care Center agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible if requested by the center.

2. The parent/guardian authorizes Zoe Child Care Center to obtain immediate medical care if any emergency occurs when he/she cannot be located immediately. *

3. The parent/guardian agrees to Zoe Child Care Center's rules and regulations as described in the policy guidelines.

4. The parent/guardian agrees to inform the center within 24 hours or the next business day after his/her child or any member of the immediate household has developed a reportable communication disease as defined by the State Board of Health, except for life threatening diseases which must be reported immediately to a local medical facility.

The parent/guardian agrees to read the Parent Handbook and will cooperate fully in seeing that the established rules and regulations are followed.

**** If there is an objection to seeking emergency care, a statement should be obtained from the parents or guardian that states their objection and the reason for their objection.**

Signature:

______________________________	______________________________
Parent/Guardian Signature	*Date*
______________________________	______________________________
Enrolled Students Name	*Enrolled Students Name*

SAFE SLEEP PRACTICES POLICY

Child's name: ______________________________________ Date of birth: _________________

Parent/Guardian name: ____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

7) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

I acknowledge that I have been advised of the safe sleep practices followed by the facility.

______________________________	______________________________
Parent/Guardian Signature	*Date*
______________________________	______________________________
Enrolled Students Name	*Enrolled Students Name*

PHOTOGRAPHY RELEASE POLICY

I authorize Zoe Child Care Center to use photos, and/or other likenesses of myself and/or child (or the child for whom I have legal guardianship) for any promotional materials regarding Zoe Child Care Center or Church of New Life's programs, facilities, or services.

Promotional materials bearing these likenesses may be distributed for free to the public and posted on the Zoe Child Care Center, Church of New Life websites and internet presence. Zoe Child Care affiliates reserve the right to use any photo or likeness for a time period beginning when this form is signed and ending upon written request of participant, parent, or legal guardian.

This agreement will stand for the entirety of enrollment unless other written request is received.

________ Initial here if you choose to only take pictures for developmental purposes only.

______________________________	______________________________
Parent/Guardian Signature	*Date*
______________________________	______________________________
Enrolled Students Name	*Enrolled Students Name*

UNIVERSAL FIELD TRIP PERMISSION FORM

Child's name: ______________________________________ Date of birth: _________________

Parent/Guardian name: ____

During the school year your child will have the opportunity to participate in field trips during regular school hours and past the end of the school day. Rather than requesting a permission slip for every field trip, we at Zoe Academy will issue one general permission slip for the entire school year. This permission slip covers bus and walking trips. You will be notified in advance concerning all bus trips via Brightwheel or written documentation in your child's take-home folder. If you do not wish for your child to take a particular field trip, please notify the school in writing before the trip occurs. By completing and submitting this form you will help us to properly supervise and ensure the safety of your child in a manner consistent with your expectations.

If you have more than one child attending Zoe Academy, please fill out a permission slip for each child.

This slip will be kept on file by the teacher.

____

Student's First & Last Name

The above-named student has my permission to accompany his/her class on planned off-site and walking field trips during the school day and past the end of the school day. I understand that I will be notified in advance concerning all field trips.

____

Parent/Guardian Signature ***Date***

MEDICAL & EMERGENCY CARE INFORMATION

Parents, it is imperative that you take the time to accurately fill out this portion of the slip for your child. In the event of an emergency, the information on this portion of the slip will be used by staff and administrative personnel to assist with emergency care.

Student Name _____________________________________ Date of Birth ___________________________

Address ____

Parent/Guardian Name ____

Parent/Guardian can be reached on the day of the field trip at the following phone number(s):

1. ____ 2. _______________________________________

Student's Doctor _________________________________ Dr. Phone Number ________________________

MEDICAL INFORMATION & SPECIAL NEEDS FOR MY CHILD

Check all that apply:

___ None ___ Allergic to: ____

___ Significant medical conditions and treatment: ____

FORM CONTINUES ON NEXT PAGE

___ Needs to receive the following medication while on the trip:

If more than one, list additional medication and dosage in the notated section below.

Name of Medication & Dose: ____________________________________ Time to be Given: ___________

If taking medication on the field trip you must check one below:

___ Parent/Guardian will deliver medication from home supply to the school

___ Teacher should obtain this medication from my child's supply kept by the school

ADDITIONAL MEDICATION

Name of Medication & Dose: ____________________________________ Time to be Given: ___________

If taking medication on the field trip you must check one below:

___ Parent/Guardian will deliver medication from home supply to the school

___ Teacher should obtain this medication from my child's supply kept by the school

Name of Medication & Dose: ____________________________________ Time to be Given: ___________

If taking medication on the field trip you must check one below:

___ Parent/Guardian will deliver medication from home supply to the school

___ Teacher should obtain this medication from my child's supply kept by the school

I, the parent/guardian, authorize the school administrator to direct members of the school staff to assist/supervise in taking the medications listed above, and I agree not to hold liable, any member of the school staff or an individual of official capacity who is directed by me and the school administrator to assist my child in taking said medication. I understand that a chaperone, teacher, or other responsible adult designated by the Center Director may carry my child's medication. In the event of an emergency or serious illness, I request that you contact me. You have my permission to obtain any emergency care necessary to ensure my child's well being while on the trip.

____

Parent/Guardian Signature ***Date***

PARENTAL BEHAVIOR POLICY

We believe staff, students and parents are entitled to a safe and protective environment in which to work together.

RATIONALE: We believe staff, students and parents are entitled to a safe and protective environment in which to work together. Behavior that may cause harassment, alarm or distress to users of the premises is contrary to the aims of the school.

AIMS: That all members of the school community treat each other with respect.

EXPECTATIONS:

- That adults set a good example to students at all times in their interaction and behavior.
- That no members of the school community, including staff, parents or students, are the victims of aggressive, abusive or threatening behavior from other adults on the school premises.
- Physical attacks and threatening behavior, abusive or insulting language, verbal or written, to staff, governors, parents, students and other users of the school premises will not be tolerated and will result in withdrawal of permission to be on school premises.

The school reserves the right to take any necessary actions to ensure that members of the school community are not subjected to abuse. School premises are private property and parents have been granted permission from the school to be on school premises. However, in case of abuse or threats to staff, pupils or other parents, school may ban parents from entering the school.

It is also an offence under section 547 of the Education Act 1997 for any person (Including a parent) to cause a nuisance or disturbance on school premises. The Police may be called to assist removing the person concerned.

GUIDELINES

Below is a list of behavior that is considered to be serious and unacceptable on the premise of Zoe Academy and will not be tolerated towards any member of the school community. This is not an exhaustive list, but rather a list that seeks to provide general illustrations of such condemned behavior:

Shouting,: either in-person or ever the phone	Physically intimidating any person on the premises
Inappropriate posting on social networking sites will be deemed as bullying and/or defamatory	Threatening physical contact
Speaking in a aggressive/threatening tone	The use of aggressive hand gestures/exaggerated movements
Sending aggressive or abusive emails, texts, or letters	Physical Threats
Shaking or holding a fist towards another person	Swearing
Spitting	Using racist or sexist comments

Unacceptable behavior may result in the Police being informed.

______________________________ ______________________________

Parent/Guardian Signature *Date*

______________________________ ______________________________

Zoe Child Care Center Administration *Date*

ACKNOWLEDGEMENT

This form acknowledges that you have read through the Zoe Academy Parent Handbook and the Enrollment Forms packet. Please initial in the spaces below, sign at the bottom of the document, and return this packet completed in it's entirety to Zoe Academy Administration.

___________ I have access to a copy of the Zoe Child Care Center Parent Handbook. The Handbook contains policies and regulations that apply to my family.

___________ I agree to read the Parent Handbook entirely and to comply with the policies that it describes, as amended from time-to-time by Zoe Child Care Center. The policies set forth in this Handbook are subject to change by Zoe Child Care Center at any time.

___________ I have completed review of the Zoe Child Care Center Parent Handbook, and my signature below acknowledges that I have read each section and agreed to follow each procedure described therein, as amended from time-to-time by Zoe Child Care Center.

______________________________	______________________________
Parent/Guardian Signature	*Date*
______________________________	______________________________
Zoe Child Care Center Administration	*Date*

6345 Xerxes Ave S
Richfield, MN 55423
P: (612) 823 - 6822

zoeacademycc@gmail.com | www.zoechildcarecenter.com

ALLERGY & FOOD PREFERENCE INFORMATION SHEET							
Please Check the Appropriate Section in Regard to Your Child							
Substance	**May Be Exposed**	**May NOT be exposed**	**IS ALLERGIC**	**IS NOT ALLERGIC**	**Not Sure**	**Parent(s)**	**Other Family Member**
FOODS							
Peanuts							
Other Nuts/Seeds							
Citrus Fruits							
Other Fruits							
Cow's Milk							
Yogurt							
Other Dairy							
Corn							
Oats							
Wheat							
Other Grains							
Yeast							
Egg Yolk							
Egg Whites							
Soy Foods							
Fish							
Shellfish							
ENVIRONMENTAL							
Dust							
Mold Spores							
Cats							
Dogs							
Other Animals							
Pollen							
Bee Stings							
MEDICAL							
Penicillin							
Latex							

OTHER: If you have indicated anything on this sheet, please list allergies in as much detail as possible.

____

____

____

____

____

____

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: ___________________

NAME OF CHILD ____ Birth Date _______________

ADDRESS ____ Telephone ______________

PARENT(S) OR GUARDIAN ____

Date of last physical examination _____________ How long have you been seeing this child? _________________

How frequently do you see this child when he/she is not ill? ____

Does this child have any allergies (including allergies to medications)? ____

Is a modified diet necessary? ____

Is any condition present that might result in an emergency? ____

____

What is the status of the child's. . .

Vision ____

Hearing ____

Speech ____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program ____

____

____

Phone _________________________

Signature of Health Source _______________________________ Address ___________________________________

Date _________________________________ ____

Immunization Form

Name________________________________ Birthdate______________

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B					
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)					
Haemophilus influenzae type b (Hib)					
Pneumococcal (PCV)					
Polio					
Measles, Mumps, Rubella (MMR)					
Chickenpox (varicella)					
Hepatitis A					
Tetanus, Diphtheria, Pertussis (Tdap)					
Meningococcal (MCV4)					

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name ______________________________

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ______________________ Date: __________
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: ______________________ Date: __________
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on __________ (date)

by ______________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year ______________

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: ______________________ Date: __________
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: ______________________ Date: __________
(of parent/guardian)