

*Where every student is a star!*

# O’Reilly Early Learning Center

8151 Hazelbrand Rd

Covington, GA 30014

info@oreillyearlylearningcenter.com

# ENROLLMENT FORM

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entrance Date (mm/dd/yyyy) Withdrawal Date (mm/dd/yyyy) Birth date (mm/dd/yyyy)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Name (last, first, middle initial)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Nickname Gender Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (Street Address, City, State and Zip Code)

(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone Number Child's Primary Language

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Public or Private School attending, if any (school age children only)

(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Cell Telephone Number Father’s Cell Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's Name/Home Address/Telephone Number, if different from child's

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment/Address of Employment/Business Number with extension

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's Name/Home Address/Telephone Number, if different from child's

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment/Address of Employment/Business Number with extension

Regular Care Arrangements: Lives with [ ] Both Parents [ ] Mother [ ] Father [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any custody arrangements for your child? \_\_\_\_\_\_\_\_\_\_\_ If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(A court order with supporting documentation describing custody arrangements and restrictions must be provided.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Legal Guardian(s) [ ] Both Parents [ ] Mother [ ] Father [ ] Other

Transportation arrangement to and from school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The child may be released to the person(s) signing this agreement or to the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address (Street-City-State-Zip) Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child Relationship to Parent(s) or Guardian

Other identifying information (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address (Street-City-State-Zip) Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child Relationship to Parent(s) or Guardian

Other identifying information (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s doctor or clinic name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor/clinic phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child has the following special needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child’s needs while at the center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following preexisting illness, allergies, or health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child's activities restricted by any special needs, developmental disabilities, medical or other conditions? \_\_\_\_\_\_\_\_\_ If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Information

Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID or Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member Service Number (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# EMERGENCY MEDICAL AUTHORIZATION

|  |
| --- |
| Should my child suffer an injury or illness while in the care of O’Reilly Early Learning Center and the facility is unable to contact me/us immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I/We agree to keep the facility informed of changes in telephone numbers, etc. where I/We can be reached. The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child. Permission is granted to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical and transportation expenses incurred.In consideration of the registration of my child, I release O’Reilly Early Learning Center and their related companies, directors, officers, employees and agents, from any claims, losses, damages or costs (including attorneys’ fees) caused by or arising from my child’s registration, use of the facility, or participation in the programs and activities conducted by the program other than to the extent caused by the negligent or willful misconduct of the program and their related companies, directors, officers, employees and agents. |

# Release and Waiver of Liability for Administering an Asthma Inhaler

Release between O’Reilly Early Learning Center] and (parent(s)/guardian(s) name) who are the Parent(s)/Guardian(s) of (child's name). (parent(s)/guardian(s) name) have requested O’Reilly Early Learning Center provide emergency treatment for their child at O’Reilly Early Learning Center Program and take certain actions described in the child's "Asthma Care Plan" (Authorization), which is attached to this Release and is hereby incorporated by reference.

The parties agree that (parent(s)/guardian(s) name)releases O’Reilly Early Learning Center and its officers, employees or agents from all liability which may arise as a result of O’Reilly Early Learning Center administering asthma treatment or following the directions in the Authorization (including any additional physician's instructions or clarifications) as long as such employees or agents exercise reasonable care in taking such actions. (parent(s)/guardian(s) name) also releases O’Reilly Early Learning Center and its officers, employees or agents from all liability arising out of the use of any materials and/or equipment supplied by the parent(s)/guardian(s) in connection with the asthma treatment as long as such employees or agents exercise reasonable care in the use of such materials or equipment.

This Release shall be governed by the laws of the State of Georgia where O’Reilly Early Learning Center is located.

Parent Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# FAMILY AGREEMENT

PLEASE CHECK ALL THAT APPLY:

\_\_\_ The school agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

\_\_\_ TRANSPORTATION: I hereby \_\_\_ give \_\_\_ do not give − consent for my child to be transported and supervised by the operation’s employees. \_\_\_ for emergency care

\_\_\_ FIELD TRIPS: I hereby \_\_\_ give \_\_\_ do not give − my consent for my child to participate in Field Trips:

\_\_\_ 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

\_\_\_ VIDEO/PHOTOGRAPHY: I give permission for my child to be photographed and videotaped for use by or on behalf of the facility for educational, training, curriculum, marketing, observation, security, and similar purposes. \_\_\_ Yes \_\_\_ No

\_\_\_ DAYS/HOURS: O’Reilly Early Learning Center agrees to provide educational services for my child on: (circle all that apply) Monday Tuesday Wednesday Thursday Friday

from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_a.m. to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_p.m..

\_\_\_ MEALS: The program will provide meals (lunch, morning and afterschool snack) which are in compliance with United States Department of Agriculture guidelines. I agree to provide substitute meals which meet USDA guidelines in the event my child has medical reasons for a substitution and a physician’s statement.

\_\_\_ MEDICATION AUTHORIZATION: Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of child, name of medication, prescription number, if any; dosage; date and time of day medication is to be given. Medicine will be in the original container with my child’s name marked on it.

\_\_\_ AUTHORIZATION TO DISPENSE EXTERNAL PREPARATIONS: I/we authorize O’Reilly Early Learning Center employees permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

\_\_\_\_\_ Baby Wipes

\_\_\_\_\_ Band-aids

\_\_\_\_\_ Neosporin or similar ointment

\_\_\_\_\_ Bactine or similar first aid spray

\_\_\_\_\_ Sunscreen

\_\_\_\_\_ Insect Repellent

\_\_\_\_\_ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

\_\_\_\_\_ Baby Powder

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ SAFETY: My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

\_\_\_ RECORDS: I acknowledge it is my responsibility to keep my child’s records current to reflect any significant changes as they occur, e.g. telephone numbers, work location, emergency contacts, child’s physician, child’s health status, and immunization records, etc.

\_\_\_ INCIDENT REPORTS: The school agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable disease, which include my child.

\_\_\_ CONFERENCES/PROGRESS REPORTS: I am advised that the school will notify me of my child’s progress, issues relating to his/her care and any individual special needs.

\_\_\_ PARENT INVOLVEMENT: O’Reilly Early Learning Center encourages parents to volunteer and attend all functions. I will receive monthly communication regarding these events and opportunities.

\_\_\_ VOLUNTEER: I volunteer to work \_\_\_\_\_\_ hours a week/month with the school.

\_\_\_ ATTENDANCE: Child’s arrival time \_\_\_\_\_\_ Child’s departure time\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ ILLNESS: Notify the staff when my child or any family member has a contagious disease.

\_\_\_ CARE PLANS/HEALTH ASSESSMENTS: I agree to obtain special care plan(s) and health assessment(s) for my child according to the schedule recommended by the American Academy of Pediatrics or required by state rules and regulations.

\_\_\_ NO EMPLOYMENT: I will not solicit, employ or enter into any contract with any employee of O’Reilly Early Learning Center to perform child care or similar services under any circumstances without the express consent of O’Reilly Early Learning Center If I employ or contract with any employee of O’Reilly Early Learning Center or person who within one year of the date of such employing or contracting was employed or under contract with O’Reilly Early Learning Center, I will pay the school a placement fee of $5,000.

\_\_\_ PARENT HANDBOOK: I have received, reviewed and understand the Parent Handbook and related information concerning the school and the educational services provided by O’Reilly Early Learning Center. I will use the program in accordance with the terms of the Parent Handbook and the policies and procedures made available at the facility. Use of the facility and the services may be denied in the event I do not comply with the terms of this Agreement, or when determined by the administration to be in the best interests of my child or the children enrolled in the afterschool program. The availability of these services are subject to change at any time.

\_\_\_ REGISTRATION AND PAYMENTS: Registration must be fully completed prior to my child attending the afterschool program. Where applicable, all registration fees and/or tuition fees must be paid in connection with the registration of my child and use of the program.

\_\_\_ TERMINATION OF ENROLLMENT: If the parent/legal guardian terminates the child’s enrollment,

we will suggest an approach to provide a comfortable transition for your child. Refund of payments for services will be limited to policies outlined in the handbook. In the event of noncompliance with the conditions described in the admission agreement and policies that the parent/legal guardian reviewed, accepted, and signed, we will meet with the parent/legal guardian to make a plan for corrective action that specifies the expected action and the period after which termination will occur for continued noncompliance. Program staff members will offer support to the family to achieve compliance and follow the school's grievance procedure. If the corrective action plan is not successful, unless the grievance procedure results in an alternative approach, termination of services will occur. Parent/legal guardian is responsible for fees as outlined in the termination policy (usually equal to one week's tuition).

RECEIPT OF WRITTEN OPERATIONAL POLICIES:

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

Signature (Parent/Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Food Allergy Action Plan

I/we provideconsent for my/our child's health care professional to release information and to communicate with my/our child’s teacher/child care provider to discuss information relating to this care plan.

Parent/legal guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**D.O.B:**\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIC TO**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STEP 1: TREATMENT**

|  |  |
| --- | --- |
| **Symptoms:** Asthmatic: Yes\* No \*Higher risk for severe reaction  | **Give Checked Medication\*\*:** \*\*(To be determined by physician authorizing treatment)  |
|  If a food allergen has been ingested, but *no symptoms*:  |  Epinephrine  Antihistamine  |
| Mouth Itching, tingling, or swelling of lips, tongue, mouth  |  Epinephrine  Antihistamine  |
| Skin Hives, itchy rash, swelling of the face or extremities  |  Epinephrine  Antihistamine  |
| Gut Nausea, abdominal cramps, vomiting, diarrhea  |  Epinephrine  Antihistamine  |
| Throat† Tightening of throat, hoarseness, hacking cough  |  Epinephrine  Antihistamine  |
| Lung† Shortness of breath, repetitive coughing, wheezing  |  Epinephrine  Antihistamine  |
| Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness  |  Epinephrine  Antihistamine  |
| Other† \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  Epinephrine  Antihistamine  |
| If reaction is progressing (several of the above areas affected), give:  |  Epinephrine  Antihistamine  |

†Potentially life-threatening. The severity of symptoms can quickly change.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Antihistamine (must be completed for over the counter and prescription medications):** give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_medication/dose/route \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:**

give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ medication/dose/route \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Needed Accommodations (Please describe accommodation and why it is necessary. Attach additional pages if needed to provide complete information.):

Special equipment or medical supplies:

Training needed for staff:

**STEP 2: EMERGENCY CALLS**

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Emergency contacts:

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Phone Number(s) |
|  |  |  |
|  |  |  |
|  |  |  |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adapted from the Food allergy and Anaphylaxis Network *Food allergy care plan* www.foodallergy.org

HEALTH CARE PLAN FOR ASTHMA MANAGEMENT

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_

Parent/Guardian #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship Phone

Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have allergies? □ No □ Yes

What triggers an asthma episode (check all that apply)

 □ Exercise □ Animals □ Pollen □ Mold □ Dust/chalk dust

 □ Respiratory infections □ Change in temperature □ Strong odors/fumes

 □ Food \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early symptoms of an asthma episode (check all that apply)

 □ runny nose □ coughing □ itchy throat

 □ sneezing □ wheezing □ tightness in chest

 □ irritable □ short of breath □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have any activity restrictions? □ No □ Yes, (health care provider note needed)

Has the student been hospitalized for an asthma episode? □ No □ Yes, when: \_\_\_\_\_\_\_\_\_\_

Does the student recognize early symptoms of his/her asthma episodes? □ No □ Yes  Some

Will a peak flow meter be used during school hours? □ No □ Yes, (authorization needed)

 Green Zone – doing well; can participate in usual activities: 80% or more personal best \_\_\_\_\_\_

 Yellow Zone -- asthma control unstable; having symptoms: 50-79% of best peak flow \_\_\_\_\_\_\_

 RED ZONE – Medical Alert; assistance needed, call parents and 911: less than 50% \_\_\_\_\_\_\_

Please list asthma medication(s): □ None □ As needed □ Daily

|  |  |  |
| --- | --- | --- |
| Name of medication(s) | When/ how many times per day | Oral / Inhaler / Nebulizer |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Will asthma medication be needed during school hours? □ No □ Yes, (authorization needed)

Please provide written authorization for all forms. Medication authorization forms must be signed every ten days. Care plans must be updated quarterly or as prescriptions or conditions change. Emergency Plan:

Steps to take during an asthma episode:

1. Check peak flow, if authorized by health care provider.
2. Give medication(s), as authorized by health care provider.
3. If student condition does not improve within 15-20 minutes, notify parent.
4. Seek emergency medical care if the student has any of the following:
* Coughs constantly, breathes more than 50 bpm at rest
* No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
* Difficulty breathing with: chest and neck pulled in, stooped body posture, struggling or gasping for air
* Trouble walking or talking
* Stops playing and cannot start activity again
* Lips or fingernails are blue or gray

Other recommendations or accommodations:

*The information on this form will be shared with staff who have a need to know.*

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**O’Reilly Early Learning Center**

8151 Hazelbrand Rd

Covington, GA 30014

info@oreillyearlylearningcenter.com

#

# Infant/Toddler Feeding and Care Plan

In an attempt to smoothly facilitate your child’s transition into our class, please fill out the following form. This information is confidential.

Child's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child take a bottle? Yes [ ] No [ ]

Is the bottle warmed? Yes [ ] No [ ]

Does the child hold own bottle? Yes [ ] No [ ]

Can the child feed self? Yes [ ] No [ ]

Does the child eat:

 Strained Foods [ ] Whole Milk [ ]

 Baby Foods [ ] Table Food [ ]

 Formula [ ] Other [ ]

What type formula used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of formula to be given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updated amounts of formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child take a pacifier? Yes [ ] No [ ]

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food likes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food dislikes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies- including any premixed formula \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child's Schedule**

Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate Time Types and approximate amount of food

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate Time Types and approximate amount of food

Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate Time Types and approximate amount of food

Morning Nap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Afternoon Nap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate Time Approximate Time

Instructions for the introduction of solid foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As needed, please list updated instructions regarding adding new foods or other dietary changes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced any feeding problems? (Please describe in detail) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child: \_\_ breast fed \_\_ bottle fed \_\_ weaned

Supplemental infant information:

Describe your child’s present napping pattern \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child usually cry when going to sleep? \_\_ No \_\_ Yes

Does your child cry when waking? \_\_ No \_\_ Yes

Do you have any special ways of helping your child go to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elimination patters (toileting/diapering): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Things that comfort or scare your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural habits/issues that may affect your child’s behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who will care for your child when he/she is sick: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any special needs (serious illness, medications, treatments, allergies, food intolerance, conditions, behaviors, etc.? Please describe and have your pediatrician submit a care plan and update it every 90 days.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any surgical procedures? \_\_ No \_\_ Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What special training, if any, must the staff have to provide care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate which of the following diseases your child has previously experienced:

\_\_ Whooping Cough \_\_ Pneumonia \_\_ Mumps

\_\_ Chicken Pox \_\_ Measles (10 day) \_\_ Allergies

\_\_ Eczema \_\_ High Temperature (Over 103) \_\_ Neurological

\_\_ Roseola (24 Hr. Measles) \_\_ Rubella (3 day-German Measles) \_\_ Recurrent Ear Infections

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take a moment to tell us anything else that would help us to provide the best care for your child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_