Nehemiah CENTER

Application Check List

Kindergarden- High School	Pre- Kindergarden
1) ☐ Please attach a copy of your STAAR	1) ☐ Completed Meal Application Form
2) ☐ Last Report Card (Most Recent Copy)	2) ☐ Copy of immunization Record
3) ☐ Standford Scores	3) ☐ Completed Medical Form
4) ☐ Completed Meal Application Form	4) ☐ ***Residential Verification (Utility Bill w/current address***
5) ☐ Copy of Immunization Record	5) ☐ 1040 ***Income Verification or letter from the employer***
	6) ☐ Birth Certificate

Name of Child:_____ **Grade Level:**_____

(Please Print) **School:**_____

Please return all completed admission forms to Mr. Perez or Mrs. Jordan

(Do not write below this line)

Office Use Only

_____ **Application Date**

_____ **Application Approval Date (all items are present)**

_____ **Enrollment Date**

_____ **Start Date (Billing Begins)**

Form J-800-2935
Revised June 2017

ADMISSION INFORMATION

Purpose: Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

GENERAL INFORMATION

Operation's Name: Nehemiah Center	Director's Name: Tonia Labbe	
Child's Full Name:	Child's Date of Birth:	Child Lives With: ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian
Child's Home Address:		
Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian (if different from the child's):	

List telephone numbers below where parents/guardian may be reached while child is in care.

Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File: ☐ Yes ☐ No

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

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

Name and Phone Number:	Name and Phone Number:	Name and Phone Number:

CONSENT INFORMATION

CHECK ALL THAT APPLY:

1. TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

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

2. FIELD TRIPS

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trips.

Comments:

3. WATER ACTIVITIES

I give consent for my child to participate in the following water activities:

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

CONSENT INFORMATION

CHECK ALL THAT APPLY:

4. RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including those for:

☐ Discipline and guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medications
☐ Procedures for conducting health checks	☐ Immunization requirements for children
☐ Safe sleep	☐ Meals and food service practices
☐ Procedures for parents to discuss concerns with the director	☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to participate in operation activities	☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

5. MEALS

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

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Phone Number:
Name of Emergency Care Facility:	Address:	Phone Number:

I give consent for the facility to secure any and all necessary emergency medical care for my child.	Signature - Parent or Legal Guardian

CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

If YES, a physician's document/statement must be signed and returned.

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

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

Signature - Parent or Legal Guardian:	Date Signed:

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:	School Phone Number:

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

ADMISSION REQUIREMENT

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

Please check only one option:

1. ☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Health Care Professional's Signature:	Date Signed:

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:	Date Signed:

REQUIREMENTS FOR EXCLUSION

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

VISION EXAM RESULTS

R 20/	L 20/	☐ Pass ☐ Fail
Signature:	Date Signed:	

HEARING EXAM RESULTS

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ Fail
Signature:			Date Signed:	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose) 1–2 months (second dose) 6–18 months (third dose)	
Rotavirus	2 months (first dose) 4 months (second dose) 6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose) 4 months (second dose) 6 months (third dose) 15–18 months (fourth dose) 4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Pneumococcal	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose) 4 months (second dose) 6–18 months (third dose) 4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose) 4–6 years (second dose)	
Varicella	12–15 months (first dose) 4–6 years (second dose)	
Hepatitis A	12–23 months (first dose) The second dose should be given 6 to 18 months after the first dose.	

PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

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

Signature :	Date Signed:

VARICELLA (CHICKENPOX)

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

Parent's Signature:	Date Signed:

ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shtm.

TB TEST (IF REQUIRED)		
☐ Positive	☐ Negative	Date:

GANG FREE ZONE
Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

PRIVACY STATEMENT
DFPS values your privacy. For more information, read our Privacy and Security Policy online at http://www.dfps.state.tx.us/policies/privacy.asp.

SIGNATURES	
Child's Parent or Legal Guardian: X	Date Signed:
Center Designee: X	Date Signed:

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following allergens: _____

THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

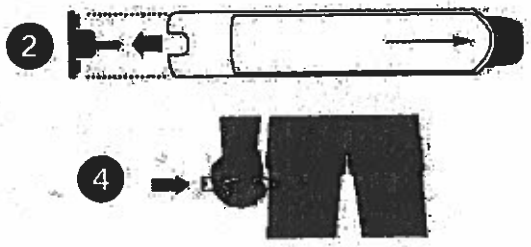
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

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



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

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

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

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

Soy Milk Request Notification Form

Provider's Name: _____

Participant's Name: _____ **Participant's Age:** _____

To: Parents or guardians of children ages 1 year and older or adult participant

Your care provider participates in the Child and Adult Care Food Program (CACFP). The CACFP is administrated by the District of Columbia Office of the State Superintendent of Education and is funded by the United States Department of Agriculture (USDA). The CACFP provides reimbursement for healthy meals prepared and served by your provider. Your provider follows the USDA Meal Pattern Requirements and is required to provide specific food groups in specific quantities in order to receive reimbursement for the meals served. The required CACFP food groups are: milk, bread/bread alternate, fruit, vegetable, and meat/meat alternate.

USDA allows providers participating in CACFP to serve approved soy milks in place of cow's milk at the request of and with written notification from the parent, guardian or adult participant. Providers may also claim reimbursement if the parent, guardian, or adult purchases and provides an approved soy milk along with written notification. Completing this form counts as written notification.

USDA-APPROVED SOY MILKS

USDA recognizes seven soy milks as allowable substitutions for cow's milk. These soy milks have been specially formulated to be nutritionally equivalent to cow's milk. The following soy milks are the only non-dairy beverages that may be substituted for milk as part of reimbursable CACFP meals.

- 8th Continent Original Soy Milk
- Pacific Natural Ultra Soy Milk
- Pacific Natural Ultra Soy Milk, Vanilla
- Safeway Lucerne Original Soy Milk
- Kikkoman Pearl Organic Soymilk Smart, Creamy Vanilla
- Kikkoman Pearl Organic Soymilk Smart, Chocolate
- WhiteWave Foods Silk® Original Soymilk

Provider-Supplied Soy Milk: _____

If you would like the USDA-approved soy milk listed above to be served in place of cow's milk, please check the box below and return this form to your care provider.

[ ] **I will ACCEPT THE PROVIDER-SUPPLIED soy milk as part of the meal.**

[ ] **I will PURCHASE ONE OF THE APPROVED SOY MILKS ON MY OWN and bring it to my provider to be served with meals.** I understand that my provider cannot receive reimbursements for meals served if I bring an unapproved brand of soy milk or other non-dairy beverage.

List the participant's medical or special dietary restriction: _____

_____ _____

Signature of Parent or Guardian or Adult Participant **Date**

_____

Printed Name of Parent or Guardian or Adult Participant

NOTE: If your child has a special dietary need and a medical authority requires a non-dairy milk substitute that is **NOT** listed on this form, please ask your child care provider for a **Medical Substitution Form**.

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 eligibility 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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

THE NEHEMIAH CENTER

Parent Data

Today's Date _____

Name of Mother _____ Number of years at Nehemiah_____
New_____

Single _____ Married _____ Divorced/Separated ____

Mother's Occupation/Employer _____

Home Phone _____Work Phone _____Cell Phone _____

Email Address _____

Home Address _____

Education: Highest level of education completed?

High School or less Some College Associate Degree College Degree Post-Graduate

Annual Household Income _____

Name of Father (or Guardian) _____

Single _____ Married _____ Divorced/Separated ____

Father's Occupation/Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Home Address (if different from mother's) _____

Education: Highest level of education completed?

High School or less Some College Associate Degree College Degree Post-Graduate

List <u>everyone</u> in your household and ages:

1._____ ____ 2. _____ ____

3._____ ____ 4. _____ ____

5._____ ____ 6. _____ ____

7._____ ____ 8._____ ____

PARENT/GUARDIAN ACKNOWLEDGMENT FORM ~~2017-2018~~ 2019-2020

Please write and sign your name at the bottom of the page to certify that you agree with the following statements regarding policies and/or expectations of the Nehemiah Center. Return signed copy to staff.

A. I have read and understood the policies and expectations set forth in the Nehemiah Center, Inc. Parent Handbook. I agree to abide by the policies and will work towards remaining in good standing with the Center to ensure my child's enrollment privileges in the Center's programs.

B. I agree that the Nehemiah Center. Inc. shall not be responsible for any personal injuries or losses sustained by my child(ren) while on the Center's premises or in vehicles as a result of any Nehemiah sponsored activities. I further agree to indemnify and hold harmless the Nehemiah Center from any claims or demands arising out of any such injuries or losses.

C. I give authorization for my child to be photographed, videotaped, and or digitally recorded for all purposes toward the Center's daily operations. This includes, but is not limited to: **Annual Newsletters; Thank You Letters; Photo Albums; Off-Campus Activities; Family Services; Volunteer Program; College Prep Program; Fundraising & Development; Marketing & Advertising.**

D. I acknowledge that report cards and other standardized test scoring are to be received by the Director of Education from myself or my child **upon the day of the release of academic information** that is set by HISD. I understand that photocopies of academic grades and/or test scores will be kept in my child's individual academic file. In the event that academic reporting is not received within one week of release from the school, the Director of Education reserves the right to contact the school about my child's grades and overall conduct.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Names of Child(ren) _____

Date _____