Nehemiah CENTER

# Application Check List

| Kindergarten – High School | | Pre-Kindergarten | |
|---|---|---|---|
| 1. ☐ | Please attach a copy of your STAAR | 1. ☐ | Completed Meal Application Form |
| 2. ☐ | Last Report Card (Most Recent Copy) | 2. ☐ | Copy of Immunization Records |
| 3. ☐ | Standford Scores | 3. ☐ | Complete 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 employer |
| | | 6. ☐ | Birth Certificate |

Last Name (child) _____ First Name (Child) _____

School _____ Grade Level _____

**Please return all completed admissions 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)

TEXAS Health and Human Services

**Form 2935**
January 2019-E

# Admission Information

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 | Director's Name |
|---|---|
| Nehemiah Center | 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) |
|---|---|
| | EMAIL: |

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 | 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

**4. Receipt of Written Operational Policies (Check All that Apply)**

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

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL 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 | A.M. | P.M. |
|---|---|---|
| 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** |
| TEXAS CHILDRENS HOSPITAL | 6621 Fannin Street Houston, Texas | 713-824-1000 |

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:

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 | 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

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

## 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.

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.

_____ _____
Signature — Health Care Professional 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 | 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

Right Eye 20/ Left Eye 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) | |
| Pneumococcal | 2 months (first dose) | |
| | 4 months (second dose) | |
| | 6 months (third dose) | |

| Vaccine | Vaccine Schedule | Dates Child Received Vaccine |
|---|---|---|
| | 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.

_____ _____
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

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

## Signatures

| | |
|---|---|
| Child's Parent or Legal Guardian | Date SIgned |
| Center Designee | Date SIgned |

# 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 received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

**Part 3.** If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, Migrant Coordinator at Phone #] Homeless ❑ Migrant ❑ Runaway❑

**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** | | | |
|---|---|---|---|---|
| | 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 | $ / Select One |
| | $ / Select One | $ / Select One | $ / Select One | $ / Select One |
| | $ / Select One | $ / Select One | $ / Select One | $ / Select One |
| | $ / Select One | $ / Select One | $ / Select One | $ / Select One |
| | $ / Select One | $ / Select One | $ / Select One | $ / Select One |
| | $ / Select One | $ / Select One | $ / Select One | $ / Select One |

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. **If Part 3 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 Statement on the back of this 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<br>❑ Not Hispanic or Latino | ❑ Asian<br>❑ White<br>❑ Black or African American<br>❑ American Indian or Alaska Native<br>❑ Native Hawaiian or Other Pacific Islander |

**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: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

| Household size | Yearly |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| Each additional person: | |

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) case 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:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

# FARE Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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**
Shortness of breath, wheezing, repetitive cough

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

**THROAT**
Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**
Significant swelling of the tongue or lips

**SKIN**
Many hives over body, widespread redness

**GUT**
Repetitive vomiting, severe diarrhea

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

**OR A COMBINATION** of symptoms from different body areas.

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

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

## **MILD** SYMPTOMS

**NOSE**
Itchy or runny nose, sneezing

**MOUTH**
Itchy mouth

**SKIN**
A few hives, mild itch

**GUT**
Mild nausea or discomfort

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

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

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

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 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

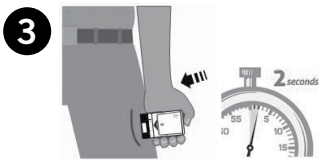
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

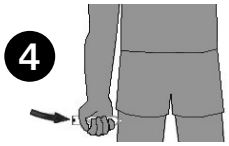
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



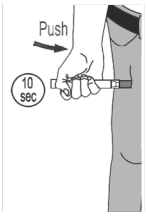

## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.


## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.


## 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: _____

NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

# Parent/Guardian Acknowledgement Form

***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 Houston Independent School District (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 _____

Nehemiah CENTER

# Parent/Guardian Acknowledgement Form

Please acknowledge receipt of the **"Parent's Guide to Child Care"** by Signing below.

Local Child-Care Licensing Office
PO Box 16014
Houston, Texas 77222-6017

Parent/Guardian Name _____

Parent/Guardian Signature _____

Names of Child(ren) _____

Date _____

Nehemiah CENTER

# Parent Data

Today's Date _____

Mother's Name _____ # of years at Nehemiah _____ Check if New ☐

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

Mother's Occupation _____ Name of Employer _____

Cell Phone _____ Work Phone _____ Home Phone _____

Email Address _____

Home Address _____

Education: Highest level of education completed?

☐ High School or Less ☐ Some College ☐ Associates Degree ☐ College Degree ☐ Post-Graduate

Annual Household Income _____

---

Father's Name _____ # of years at Nehemiah _____ Check if New _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

Father's Occupation _____ Name of Employer _____

Cell Phone _____ Work Phone _____ Home Phone _____

Email Address _____

Home Address (if different from mother's) _____

Education: Highest level of education completed?

☐ High School or Less ☐ Some College ☐ Associates Degree ☐ College Degree ☐ Post-Graduate

---

**LIST EVERYONE IN YOUR HOUSEHOLD:**

| Last Name | First Name | Age | Grade |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
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