

**FORM NO. 1**  
**ADMISSION INFORMATION**

Operation Name <b>Crown of Life Lutheran School</b>	Director's Name <b>Diane Dillow</b> Operation ID # <b>197796</b>
--	---

Child's Full Name	Child's Date of Birth	Child's Main Telephone No.
-------------------	-----------------------	----------------------------

Child's Home Address <p style="text-align: right;">San Antonio, TX 782</p>
---

Date of Admission	Date of Withdrawal	My child is normally in care on the following days and times:
-------------------	--------------------	---

Parent's or Guardian's Name	Address (if different from child's address)
-----------------------------	---

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No
------------------------	------------------------	--------------------------	---------------

Give the name, <b>address</b> and phone number of person to call in case of an emergency if parents / guardian cannot be reached: <p style="text-align: right;">San Antonio, TX 782</p>	Relationship
--	--------------

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

Name and Phone	Name and Phone	Name and Phone
----------------	----------------	----------------

**CHECK ALL THAT APPLY:**      I hereby      give      do not give      – consent for my child to be transported and supervised by the operation's employees.

1.  **TRANSPORTATION:**  
for emergency care

2.  **FIELD TRIPS:**    I acknowledge that **Crown of Life Lutheran School does NOT participate in field trips.**

3. **WATER ACTIVITIES:**    I hereby  give      do not give      – my consent for my child to participate in Water Activities:  
sprinkler play      splashing/wading pools       water table play

4.  **RECEIPT ELECTRONIC DISTRIBUTION OF WRITTEN OPERATIONAL POLICIES.**  
I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

6. **I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:**  
 None       AM Snack       Lunch       PM Snack

**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: <p style="text-align: right;">San Antonio, TX 782</p>	Ph.#:
Name of Emergency Medical Care Facility:	Address: <p style="text-align: right;">San Antonio, TX 782</p>	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

\_\_\_\_\_  
Signature - Parent or Legal Guardian

**ANY KNOWN SPECIAL NEEDS OR HEALTH CONCERNS:**  
List any special problems that your child may have, such as allergies, 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 such as speech or developmental delay, behavioral or learning needs which caregivers should be aware of:

Child daycare 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

**Discipline and Guidance Policy for CROWN OF LIFE LUTHERAN SCHOOL**

- ◆ Discipline must be:
  1. Individualized and consistent for each child.
  2. Appropriate to the child’s level of understanding; and
  3. Directed toward teaching the child acceptable behavior and self-control.
  
- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  1. Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  2. Reminding a child of behavior expectations daily by using clear, positive statements;
  3. Redirecting behavior using positive statements; and
  4. Using brief supervised separation or time out from the group, when appropriate for the child’s age and development, which is limited to no more than one minute per year of the child’s age.
  
- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  1. Corporal punishment or threats of corporal punishment;
  2. Punishment associated with food, naps, or toilet training;
  3. Pinching, shaking, or biting a child;
  4. Hitting a child with a hand or instrument;
  5. Putting anything in or on a child’s mouth;
  6. Humiliating, ridiculing, rejecting, or yelling at a child;
  7. Subjecting a child to harsh, abusive, or profane language;
  8. Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  9. Requiring a child to remain silent or inactive for inappropriately long periods of time for the child’s age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

PLEASE PRINT

Child’s Name \_\_\_\_\_ Parent’s Name \_\_\_\_\_

My signature verifies I have read and received a copy of the Discipline and Guidance Policy.

Signature

\_\_\_\_\_ Date

Check one please:            parent            employee/caregiver

**FORM NO. 3**

**CROWN OF LIFE LUTHERAN SCHOOL  
MEDICAL INFORMATION FORM**

(For physician to complete and valid one year from date)

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Address \_\_\_\_\_

Parent's Name \_\_\_\_\_

**Immunization Record**

A **copy** of the immunization record along with this form signed by a physician must be in each child's file **by the first day of enrollment**. Children must have required immunizations to attend school. Each immunization record must be signed or stamped by a physician.

***A information sheet on required immunizations is available upon request.***

\_\_\_\_\_ has been examined by a medical doctor and found to be physically and mentally able to participate in all school activities.

Restrictions: \_\_\_\_\_

Has the child had any major surgery or has he/she been hospitalized within the last twelve months?

\_\_\_\_\_ Describe \_\_\_\_\_

Known allergies? (List allergic medications) \_\_\_\_\_

food? \_\_\_\_\_

other? \_\_\_\_\_

What if any medications does child take on a regular basis? \_\_\_\_\_

**SIGNATURE OF PHYSICIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

Phone \_\_\_\_\_ Physician's Address \_\_\_\_\_

Children must have vision and hearing screening by their 4th birthday.

VISION R20/ \_\_\_\_\_ L20/ \_\_\_\_\_      PASS      FAIL

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

HEARING	1000 Hz	2000 Hz	4000 Hz		
R					<u>    </u> PASS <u>    </u> FAIL
L					

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN**

**PRINT**

**SIGNATURE**

**DATE**

**CROWN OF LIFE LUTHERAN SCHOOL  
FAMILY HISTORY-PERMISSION-CHILD RELEASE FORM**

*PLEASE PRINT*

Child's Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_

Has child been baptized? \_\_\_\_\_ Where \_\_\_\_\_ Date \_\_\_\_\_

Church family attends \_\_\_\_\_

Has your child had play group/preschool experience? \_\_\_\_\_  
Where? \_\_\_\_\_

Does your child prefer to play alone or with friends? \_\_\_\_\_

Child's favorite indoor activity \_\_\_\_\_

Child's favorite outdoor activity \_\_\_\_\_

How much time does your child spend watching TV daily? \_\_\_\_\_

What fear(s) does your child have? \_\_\_\_\_

What method of discipline is used in your home? \_\_\_\_\_  
\_\_\_\_\_

What is your child's usual reaction? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_  
\_\_\_\_\_

Is your child right-handed or left-handed? \_\_\_\_\_

Does your child have bladder or bowel irregularities? \_\_\_\_\_  
\_\_\_\_\_

Family History-Permission-Child Release Form – Page 2

Does your child have any allergies (please also list on the allergy and food form)?

\_\_\_\_\_

Are there any medical concerns of which we should be aware? \_\_\_\_\_

\_\_\_\_\_

Please let us know about the following services your child receives:

Speech Therapy Physical Therapy Occupational Therapy Play Therapy Behavioral Therapy

ECI Services: Brighton Center Easter Seals PPCD at \_\_\_\_\_ elementary  
Notes:

\_\_\_\_\_

\_\_\_\_\_

PHOTO PERMISSION

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission for my child’s photograph in a group or individual to be taken and used for Crown of Life Lutheran School’s use within the facility, COL website, or in publication format. NOTE: Your child’s name will be withheld if photo is used on COL website and publication format (examples are send photo card to military, nursing homes, etc.)

CLASSROOM DIRECTORY PERMISSION

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission for my child’s name, address, birthday, telephone number and our email address(es) to be released ONLY to classroom parents.

Father’s Printed Name and  
Signature \_\_\_\_\_

Mother’s Printed Name and Signature \_\_\_\_\_

CHILD RELEASE - PLEASE INCLUDE PARENTS NAMES

\_\_\_\_\_ has my permission to be picked up from school by the following person (s).

NAME RELATIONSHIP TELEPHONE NO.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

I UNDERSTAND THAT MY CHILD WILL NOT BE RELEASED TO ANYONE OTHER THAN THOSE LISTED ABOVE WITHOUT MY PERMISSION.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_



## *Crown of Life Lutheran School*

### EMERGENCY INFORMATION CARD

**Please Print**

Teacher: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Name of location and phone number where parents can be reached if not at home.**

Mother: \_\_\_\_\_ Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Phone: \_\_\_\_\_

**In the event of illness and we cannot reach either parent, please list two (2) other adults who we can contact to care for your child:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### INSURANCE INFORMATION

**Please Print**

\_\_\_\_\_  
 (Policyholder) Last Name First Name Middle Name

\_\_\_\_\_  
 Address (Street, City, State and Zip) Relationship to Student

\_\_\_\_\_  
 Insurance Company (Check  Group  Individual

\_\_\_\_\_  
 Employer and Employer Address

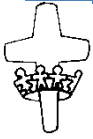
\_\_\_\_\_  
 Policy Number Group Number

\_\_\_\_\_  
 Local Physician's Name Physician's Address Physician's Phone

**Allergies or Medical Concerns**

In the event of accident or sudden illness to my child, and in the event I cannot be reached by telephone, I hereby authorize a representative of the school to refer my child to the above mentioned physician. In the event the above mentioned physician is not available, I hereby authorize a school representative to take my child to the Emergency center listed for appropriate emergency care. I also authorize First Aid Care until the above mentioned circumstances are achieved.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_



***Crown of Life Lutheran School***

**ALLERGY AND SPECIAL FOOD NEEDS CARD**

Please Print

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Teacher: \_\_\_\_\_

Please Initial items that apply and provide the necessary information:

\_\_\_\_\_ My child has NO known allergies. If this should change in the future, I will notify the Education Office.

\_\_\_\_\_ My child is allergic to \_\_\_\_\_

Allergic Reaction is \_\_\_\_\_

Special Instructions are \_\_\_\_\_

\_\_\_\_\_ Special Food or Eating Needs are \_\_\_\_\_

Parent or Legal Guardian:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date