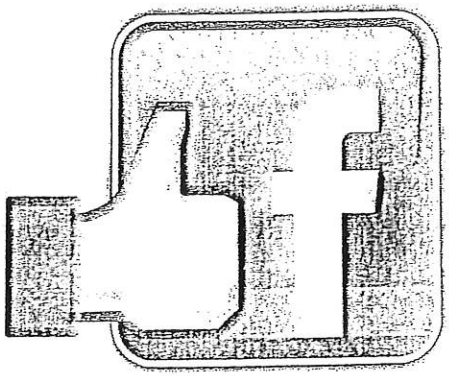
Stay up to date...

Like us on Facebook



remind

Download the remind app and us!

Our class name is God's Grace Learning Center

our class code is @akb8e4

Or text our class code to 81010

Text option does not apply to Verizon Wireless users.

MailChimp

Please sign up for our weekly newsletter.

Please sign me up for Mail Chimp.

Name	email address
Name	email address

God's Grace Learning Center Financial Agreement

All tuition is auto-drafted on Monday afternoon. You are charged a weekly rate to reserve a spot for your child(ren);the charges are not based on their attendance. This fee includes breakfast, lunch, and an afternoon snack. If your payment is returned, a $35 service fee will be applied to your account. In the event that you write a check and it is returned, there will be a $35 service fee applied to your account and we may, at our discretion, no longer accept your checks. All accounts must be paid in full by Friday afternoon or a $15 late fee will be applied to your account and your child may not return on Monday until full payment is received.

Should your account become 90 days delinquent, you will be referred to a licensed collection agency and this will affect your credit. Returned checks that are not paid for will be turned over to the local court for collection.

I have read and fully understand all of the above information including my financial responsibility and accept and agree to this Policy Program Statement and Financial Agreement.

_____ _____

Date Signature of Parent(Mother)/Guardian

_____ _____

Date Signature of Parent(Father)/Guardian

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

(we) hereby authorize (business name) _____ to initiate credit card charges to he below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, ndicated below **(Section B)**. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written iotice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

ECTION A (Credit Card)

_____
ardholder Name — Phone #

_____
ardholder Address — City — State — Zip

_____
ccount Number — Expiration Date

_____
ardholder Signature — Date

ECTION B (Bank Account)

_____
our Name — Phone #

_____
ddress — City — State — Zip

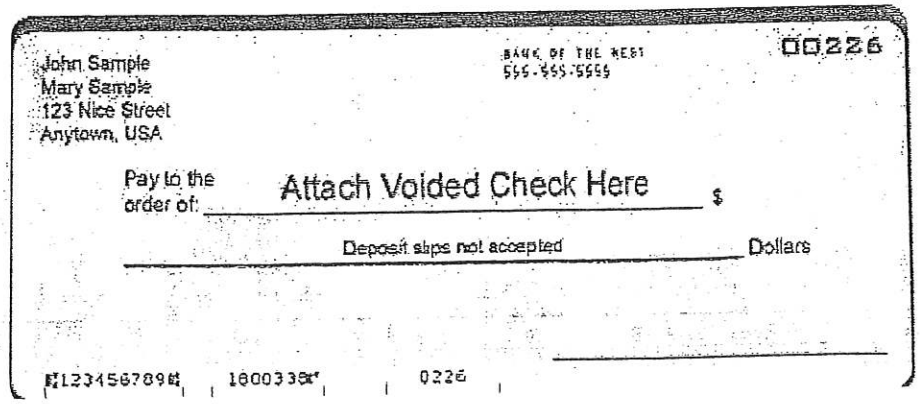
_____
ank or Credit Union Name — Bank or Credit Union Address — City — State — Zip

_____
outing Transit Number (see sample below) — Account Number (see sample below) — ☐ Checking ☐ Savings

_____
uthorized Signature — Date

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

God's Grace Learning Center - Decker Prairie
Family Registration Form

Parent / Guardian Information **Registration Date** _____

Mother /Guardian

First Name:_____ M.I. _____ Last Name: _____

Address: _____

Occupation: _____ Home Phone: _____

Employed By: _____ Office Phone: _____

Work Address: _____ Cell Phone: _____

Religion: _____ ( ) Custodial Parent (If married, mark both parents)

Mother's SS#: _____ Driver's License # _____

Email Address: _____

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Other

Father / Guardian

First Name:_____ M.I. _____ Last Name: _____

Address: _____

Occupation: _____ Home Phone: _____

Employed By: _____ Office Phone: _____

Work Address: _____ Cell Phone: _____

Religion: _____ ( ) Custodial Parent (If married, mark both parents)

Mother's SS#: _____ Driver's License # _____

Email Address: _____

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Other

Child Information

We require a copy of a current shot record as well as a copy of any and all inoculation as soon as they are given.(NOTE: If any medical diagnosis and treatment and/or immunizations conflict with your religious beliefs or would be injurious to your child or family, you must sign and affidavit to that effect and attached to this form)

1st Child

Registration Date:_____

First Name: _____M.I._____ Last Name: _____

Name child prefers to be called :_____Grade / Class _____

Child's Address: _____

Gender: ( ) Male ( ) Female Date of Birth:_____

List any existing medical condition, medications and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone : _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? ( ) Yes ( ) No

2nd Child

Registration Date:_____

First Name: _____M.I._____ Last Name: _____

Name child prefers to be called :_____Grade / Class _____

Child's Address: _____

Gender: ( ) Male ( ) Female Date of Birth:_____

List any existing medical condition, medications and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone : _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? ( ) Yes ( ) No

3rd Child

Registration Date:_____

First Name: _____M.I._____ Last Name: _____

Name child prefers to be called :_____Grade / Class _____

Child's Address: _____

Gender: ( ) Male ( ) Female Date of Birth:_____

List any existing medical condition, medications and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone : _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? ( ) Yes ( ) No

4th Child

Registration Date:_____

First Name: _____M.I._____ Last Name: _____

Name child prefers to be called :_____Grade / Class _____

Child's Address: _____

Gender: ( ) Male ( ) Female Date of Birth:_____

List any existing medical condition, medications and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone : _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? ( ) Yes ( ) No

Emergency Contacts & Authorized Pickup Persons:

(Please understand we will not release your child without specific permission from the parent.)

1st Contact / Pick Up

Name: _____ Phone : _____

Address: _____

Relationship to the child: _____ TDL#/TID#_____

( ) Able to pick up all children in the family

( ) Not able to pick up the following children: _____

2nd Contact / Pick Up

Name: _____ Phone : _____

Address: _____

Relationship to the child: _____ TDL#/TID#_____

( ) Able to pick up all children in the family

( ) Not able to pick up the following children: _____

3rd Contact / Pick Up

Name: _____ Phone : _____

Address: _____

Relationship to the child: _____ TDL#/TID#_____

( ) Able to pick up all children in the family

( ) Not able to pick up the following children: _____

4th Contact / Pick Up

Name: _____ Phone : _____

Address: _____

Relationship to the child: _____ TDL#/TID#_____

( ) Able to pick up all children in the family

( ) Not able to pick up the following children: _____

***** AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION *****

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

Name of Doctor:_____

Address:_____ Phone:_____

Name of Hospital: _____

Address: _____Phone: _____

I give my consent for God's Grace Learning Center to secure any and all necessary emergency medical care for my child.

Parent's Signature_____**Date:**_____

Transportation:

I hereby ( ) give ( ) do not give- my permission for my child to be transported and supervised by child care staff ( ) on field trips ( ) to and from school.

Water Activities:

I hereby ( ) give ( ) do not give- my permission for my child(ren) to participate in water activities ( ) Wading pool ( ) Swimming pool Exclusions:_____

School Children Only:

Name: _____ attends the following school _____
( ) His/Her immunization record is on file at the school and current. Current vision and hearing screening records are also on file.

Name: _____ attends the following school _____
( ) His/Her immunization record is on file at the school and current. Current vision and hearing screening records are also on file.

Name: _____ attends the following school _____
( ) His/Her immunization record is on file at the school and current. Current vision and hearing screening records are also on file.

Name: _____ attends the following school _____
( ) His/Her immunization record is on file at the school and current. Current vision and hearing screening records are also on file.

Movies:

I hereby ( ) give ( ) do not give my permission for my school age child(ren) to watch rated -PG movies.

Tuition / Payment Information

Please outline below who is responsible for payment of tuition and fees. Please fill out if parents are divorced and split tuition payment is the responsibility of an adult other than the parents listed above.

_____

( ) I acknowledge receipt of the operations policies and the Discipline and Guidance Policies.

Parents Signature _____ Date: _____

GOD'S GRACE LEARNING CENTER

26605 Peden Rd–Decker Prairie, TX 77355-832-521-3164

Health Statement

This form must be filled in by the doctor and presented when the child is admitted to the childcare facility or within one week of admission.

Date of last examination:_____
(Child's name)_____ has been examined by me within the last year and found that he/she is physically able to take part in the childcare program.

_____
(Physician's signature) (Phone number)

_____
(Address)

We require a copy of the child's immunization record and all updates to that record while the child is enrolled here. Please attach a copy of the immunization record to this form.

Required immunizations for children ages infancy to four years:

1. DPT (Diptheria, Pertussis (Whooping Cough), Tetanus series and booster (4)
2. Polio (Trivalent OPV) series and booster (3)
3. Measles, Mumps, and Rubella (MMR) by 16 months
4. Hib (Haemophilus influenza type B) (4)
5. Hepatitis B (3)
6. Varicella (chickenpox) After 12 months of age
7. PCV7 (2 months through 59 months)
8. Hepatitis A (2 years and older)
9. RV (Rotavirus) recommended-not required

Required inoculations for children ages 4-6 years:

1. DPT Booster (1)
2. Polio Booster (1)
3. MMR (1)

ALL IMMUNIZATIONS ARE SUBJECT TO THE DOCTOR'S DECISION AS TO WHICH INOCULATIONS ARE GIVEN AND WHEN. ANY MEDICAL CONTRADICTIONS MUST BE SUBSTANTIATED WITH AN AFFADAVIT OR CERTIFICATE SIGNED BY THE PHYSICIAN. ANY RELIGIOUS CONFLICTS MUST BE SUBSTANTIATED WITH A NOTARIZED AFFADAVIT SIGNED BY THE PARENT.

TEXAS
Health and Human Services

Form 1099
July 2019-E

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

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 or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: ☑ Parent ○ Caregiver/Employee ○ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y
- Title 26, Chapter 747 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y
- Title 26, Chapter 744 Subchapter G: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y

Field Trip Permission Form

Dear Parents,
In order for us to transport your child on field trips, we are required by TDFP to have a signed permission form. This form serves two purposes. First, it will be carried on the bus to any and all places we transport your child to. Second it gives us current information for our records.It is extremely important that we have all areas of this form completed and returned immediately. Please PRINT all information. We do require that the doctor's name ,full address, and phone number be filled out completely. If more space is needed, please use the other side. Failure to return this completed signed form may prevent your child from attending certain activities. Return immediately to the front office.

TRANSPORTATION PERMISSION FORM - PLEASE PRINT

Child's Name :_____ Birth Date:_____

Child's Home Address:_____ Phone: _____

City :_____State: _____Zip Code:_____Sex:_____ Age:_____

Mother's Name: _____ Work:_____ Cell:_____

Father's Name: _____ Work:_____ Cell: _____

Please list any allergies or medications:_____

Is your child sensitive to sun, pool water, ect? Yes _____ No _____ If yes, be specific:_____

Emergency Contact if parent /guardian can not be reached:

Name: _____ **Phone:** _____

Address:_____

Please check all that apply:

1. Transportation: I hereby ☐ give ☐ do not give - my permission for my child to be transported and supervised by child care staff

☐ On field trips ☐ to and from school

2 Water Activities : I hereby ☐ give ☐ do not give - my permission for my child to participate in water activities:

☐ Wading pools ☐ Swimming pool

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION(Please fill in ALL information)
In the event I cannot be reached to make arrangements for emergency medical attention; I authorize the child care director or person in charge to take my child to:

Name of Doctor:	Address:	Phone Number:
Name of Hospital:	Address:	Phone Number:

Child Emergency Information

Full Name:_____ DOB:_____

Emergency contact Information

1.Name:_____	Relationship:_____
Cell Phone:_____	Work Phone:_____ Ext._____
2.Name:_____	Relationship:_____
Cell Phone:_____	Work Phone:_____ Ext._____
3.Name:_____	Relationship:_____
Cell Phone:_____	Work Phone:_____ Ext._____

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

External Preparations Form

Child's Name		Date:
Child's DOB		Weight
Height	Hair Color	Eye Color

I hereby give Provider name permission to apply one or more of the following external preparations, in accordance with the directions for use on the container.

( ) Baby wipes

( ) band-aids

( ) Neosporin, bacitrician, or similar ointment

( ) bactine or similar first-aid spray

( ) * Sunscreen

( ) * insect repellent

( ) non-prescription ointment (such as A & D, Desitin, Vaseline)

( ) * Other: (please specify) _____

* Must be provided by the parent.

I hereby request that Provider name administer one or more of the above external preparations in accordance with the directions on the container as needed.

I release Provider name from any liability for administering these preparations.

By signing below, you agree that this is a legally binding form. Providing false information could result in termination of childcare services, forfeiture or retainer, or both.

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date
Provider name Signature	Date