TEXAS Health and Human Services

Form 2935
January 2025

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:		
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 1:	Address of Parent or Guardian 1 if different from the child's:		
Name of Parent or Guardian 2:	Address of Parent or Guardian 2 if different from the child's:		

List phone numbers below where parents or guardian may be reached while child is in care.

Parent 1 Area Code and Phone No.:	Parent 2 Area Code and Phone No.:	Guardian's Area Code and Phone No.:	Custody Documents on File: ◯ Yes ◯ No

In case of an emergency, when the parent or guardian cannot be reached, call:

Name of Emergency Contact:	Relationship:	Area Code and Phone No.:
Address:		

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 phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.

Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees. Check all that apply.

☐ 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. Check all that apply.

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

Is your child able to swim without assistance? ◯ Yes ◯ No If no, your child is required to wear a life jacket while in or near a swimming pool.	Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming? ◯ Yes ◯ No If yes, your child is required to wear a life jacket while in or near a swimming pool.
Do you want your child to wear a life jacket while in or near a swimming pool? ◯ Yes ◯ No	

*A competent swimmer can enter and exit a pool safely on their own, tread water or float on their back for one minute, and swim 25 yards with no assistance.

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for the following. Check all that apply.

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ 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 supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

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

☐ 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		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

8. Child's Special Care Needs, check all that apply

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations in the past 12 months
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment, include instructions below
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit www.ada.gov/resources/child-care-centers/. 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**

9. School Age Children

My child attends the following school:	School Area Code and Phone No.:

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 their sibling younger than 18 years old

Authorized pick up or 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.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Area Code and Phone No.
Name of Emergency Care Facility	Address	Area Code and Phone No.

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

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ 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**

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. Select **only one** option.

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find they are able to take part in the day care program.

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

◯ 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.

◯ 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 of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. 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)	
	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 six to 18 months after the first dose.	

Varicella for Chickenpox

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

Signature **Date Signed**

Additional Information About Immunizations

For additional information about 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**

Physician or Public Health Personnel Verification

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

Signature **Date Signed**

Welcome to Bright Beginnings Academy!
Please help us get to know your child and family by filling this out.

Name:_____ Nickname:_____

DOB: _____ Language Spoken at home: _____

Normal Drop off Time: _____ Normal Pick up Time: _____

Parent/Guardian:_____ Parent/Guardian:_____

Address: _____

Phone Number: _____ Email: _____

Parents are (circle one) Married Living Together Divorced Other

Other family members who live in your house: _____
_____

Please list any important family traditions and customs: _____
_____

Has your child been in child care before? [ ] Yes [ ] No
If so, what kind: [ ] Center [ ] Relative's Care [ ] Home Care [ ] Other: _____

Emergency Contact Name:_____

Emergency Contact Relationship:_____

Emergency Contact Phone Number: _____

Emergency Contact Name:_____

Emergency Contact Relationship:_____

Emergency Contact Phone Number: _____

Social and Emotional Behaviors

How would you describe your child's personality? _____
_____
_____

Does your child play well with peers and/or siblings?_____
Does your child prefer to play alone or with peers?_____
What is the best way to comfort your child?_____
What is your discipline method at home?_____
What are your child's special interests?_____
What are your child's favorite toys and activities? _____

Child's Health History

Does your child currently take any medications? _____
If yes, please list _____
Are there any side effects we should know about? _____

Does your child have any special needs or any conditions which would limit his or her ability to participate in The Bright Beginnings Academy School's programs, services and activities, including the ability to use school facilities and equipment? [ ] Yes [ ] No Explain:
_____
_____
_____
If yes, what modifications do you want the school to consider in providing services, or presenting programs and activities to your child?
_____
_____

Is there anything your child can't eat or drink? Identify the foods your child can't eat. [Note: If your child has severe allergies to food or anything else, please ask for a Severe Allergy Packet.]
_____

Eating, Sleeping and Toileting Routines

Can your child feed himself or herself? Please describe any assistance needed.
_____

Do you have any concerns regarding eating we should know about? _____
_____

For Infants: Please check all that apply for your baby:
Breast Milk ____ Formula ____ Cereal _____ Jar Food ____ Table Food ____ Other ____

Please describe how much and how often your baby eats: _____
_____

What is your child's typical bedtime, morning wake up time and nap time routine?

_____
_____

Is your child using diapers, training pants or underwear? Will your child tell teachers if they have to use the bathroom?

_____

General Development

Is your child walking, crawling, or not yet mobile?_____

Is your child talking in sentences, using words and phrases, or not yet using words?

_____

If your child speaks another language, please list some words we may need to use at school:

_____
_____

What developmental goals would you like the teachers to work on with your child? _____

_____

Comments and additional information: _____

_____
_____

_____ _____

Parent's/Guardian's Signature Date

Staff Only Information:

Enrollment Date:

_____

Classroom:

_____

Staff Notes:

TEXAS Health and Human Services

Form 3019
April 2018-E

Infant Sleep Exception/Health Care Professional Recommendation

When a health care professional determines that it is medically necessary for an infant to sleep in an alternative position (other than sleeping on the infant's back), sleep in a restrictive device (such as a bouncer seat or swing), or needs to be swaddled to sleep, use this form to ensure that a licensed child care center, licensed child care home, or registered child care home that cares for the infant meets the minimum standards required by Texas Human Resources Code §42.042(e)(8)(A) and (B). The standards for these operations require the operation to:

- follow the directions of an infant's health care professional to provide specialized medical assistance to the infant (746.3815 and 747.3615); and
- maintain, while active, this form and any other directions from the health care professional that the parent provides to the operation [See §746.603(a)(10) or §747.603(a)(9)]. Keep the exception form in the infant's classroom, so that a caregiver may refer to the health care professional's instructions.

Directions: This exception will not be effective until all sections and signatures are complete. Once completed, the exception is acceptable for use by the child care operation.

Infant's Information

Infant's Name	Date of Birth	Infant's Age	Parent/Guardian's Name

Address

Home Phone	Work Phone	Fax	Email

The infant's health care professional must complete the following section.

Health Care Professional Information

Name of Infant's Health Care Professional	Name of Practice

Address	Fax number

Work Phone	Home Phone	Email

The Texas child care minimum standards (§§746.2426, 746.2427 and 746.2428 for child care centers or §§747.2326, 747.2327 and 747.2328 for licensed or registered child care homes) require child care operations to place all infants on their backs to sleep in a crib and to ensure that infants do not sleep in restrictive devices and are not laid down to sleep swaddled. But, based on the advice of the infant's health care professional, when medically necessary, the center may be authorized to use an alternative sleep position, restrictive device, or swaddle for the infant due to medical reasons.

The above named infant has the following medical condition that necessitates an alternative sleep position, allow for sleep in a restrictive device, or requires swaddling for sleeping:

Health Care Professional Information

Please describe the appropriate sleep position/restrictive device/swaddling technique to be used for the above named infant and include the effective dates for the exception:

Effective Dates of Exception	From	To

Health Care Professional's Signature _____ Date _____

Waiver of Liability

- I affirm and acknowledge that the below named child care operation has provided me with the operation's safe sleep policy.
- I further authorize the child care operation and its caregivers to place my infant in an alternative sleep position, restrictive device, or swaddling at the recommendation of my infant's health care professional, as described above.
- I, as the parent or guardian of the above mentioned infant, release and hold harmless the below named child care operation, its officers, directors, caregivers, and employees from any and all liability whatsoever associated with harm to my infant due to Sudden Infant Death Syndrome (SIDS).

Parent or Guardian's Signature _____ Date Signed _____

An authorized official with the child care operation must complete the following section.

Child Care Operation Information and Signature

Name of Child Care Operation	Operation Number

Operation Representative's Signature _____ Date Signed _____

Privacy Statement

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TEXAS Health and Human Services

Form 2550
September 2023

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards Sections 746.501(9) and 747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at _____ and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at _____ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [Sections 746.2427 and 747.2327].
- Place infants on a firm mattress, with a tight-fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non full-size cribs [Sections 746.2409 and 747.2309].
- For infants who are younger than 12 months old, cribs play yards should be bare except for a tight-fitting sheet and a mattress cover or protector. Items that should not be placed in a crib or play yard include: soft or loose bedding, such as blankets, quilts or comforters; pillows; stuffed toys and animals; soft objects; bumper pads; liners; or sleep positioning devices [Sections 746.2415(b) and 747.2315(b)]. Also, infants must not have their heads, faces or cribs covered at any time by items such as blankets, linens, or clothing [Sections 746.2429 and 747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [Sections 746.2415(b) and 747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [Sections 746.3407(10) and 747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [Sections 746.2415(b) and 747.2315(b)].
- Place only one infant in a crib to sleep [Sections 746.2405 and 747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [Sections 746.2415(b) and 747.2315(b)] or the infant’s clothing by a string, cord or other attaching mechanism that might be a suffocation or strangulation risk [Sections 746.2401(6) and 747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [Sections 746.2426 and 747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [Sections 746.3703(d) and 747.3503(d)].
- Actively observe sleeping infants by sight and sound [Sections 746.2403 and 747.2303].
- If an infant can roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [Sections 746.2427 and 747.2327].
- Awake infants will have supervised “tummy time” several times daily. This will help them strengthen their muscles and develop normally [Sections 746.2427 and 747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant’s health care professional [Sections 746.2428 and 747.2328].

Privacy Statement

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Signatures

This policy is effective on: _____ Child's name: _____

_____ _____
Signature — Director or Owner Date Signed

_____ _____
Signature — Staff member Date Signed

_____ _____
Signature — Parent Date Signed

Child Photo and Social Media Release Form

Bright Beginnings Academy occasionally photographs and records events, activities, and projects to document our programs and to share our students' achievements with the community. We request your permission to use images and videos of your child for these purposes. Please complete the form below to indicate your preferences.

Child Information

- **Child's Name:** _____
- **Date of Birth:** _____

Parent/Guardian Information

- **Parent/Guardian Name:** _____
- **Contact Number:** _____
- **Email Address:** _____

Photo and Video Release

I, the undersigned, hereby grant permission for Bright Beginnings Academy to use photographs, videos, and/or digital images of my child for the following purposes (please check all that apply):

1. **Internal Use:**
   - Displays, presentations, and educational purposes within the Academy
   - **Yes** [ ] **No** [ ]
2. **Promotional Materials:**
   - Printed materials, brochures, newsletters, and other promotional items
   - **Yes** [ ] **No** [ ]
3. **Media:**
   - Local newspapers, magazines, and television broadcasts
   - **Yes** [ ] **No** [ ]

Social Media Release

I also grant permission for Bright Beginnings Academy to use images and videos of my child on the Academy's official social media channels, including but not limited to Facebook, Instagram, and Twitter.

- **Yes** [ ] **No** [ ]

Acknowledgment

I understand that these images and videos may be used in public forums and that my child's identity may be revealed. I hereby release and discharge Bright Beginnings Academy, its staff, and participating photographers from any and all claims and demands arising out of or in connection with the use of these images.

- **Parent/Guardian Signature:** _____
- **Date:** _____

Respect for Privacy of Other Children

Bright Beginnings Academy respects the privacy and wishes of all families involved in our programs. We kindly ask parents and guardians to refrain from posting images or videos of other children from the Academy without explicit permission from their respective parents or guardians. This ensures that all families' privacy preferences are honored and respected.

By signing below, you acknowledge your agreement to this clause and affirm your commitment to respecting the privacy of all children and families at Bright Beginnings Academy.

Parent/Guardian Signature

_____

Date:

_____

Thank you for supporting Bright Beginnings Academy's efforts to share the wonderful experiences our students enjoy. If you have any questions, please contact us at director@brightbeginningsacad.com

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Please return this completed form to the office.

Authorization for Recurring Billing via ACH

(Section above the dotted line to be shredded after the information is entered into FMS. Section below the dotted line to be retained.)

Name of Child(ren):_____

Name of Parent(s)/ Name(s) on Bank Account: _____

Parents' Email: _____

Name of Bank: _____

Bank Routing #: _____

Bank Account #: _____

Driver's License State:

Driver's License #: _____

- Statement of Authorization

I, _____ , hereby authorize Bright Beginnings Academy, LLC. to withdraw from my bank account ending in _____ all amounts due under the Enrollment Agreement. The withdrawal will be made once a month on the 1st day of the month. This Authorization is valid for a period of 12 months beginning on the date set forth below.

Signature: _____ **Date**:_____

Please provide 10 days advance notice if you wish to stop automatic withdrawals. If you fail to do so and the School incurs bank fees, you agree to reimburse the School for the bank fees. A copy of this Statement of Authorization will be retained for the School's records, but your bank account information will be shredded for your protection.

Photo Release/ Adult

In consideration of my participation in activities and special events sponsored by Bright Beginnings Academy, I hereby consent to Bright Beginnings Academy taking photographs of me, both at the center and at any off premises events sponsored by Bright Beginnings Academy. I agree that I have no rights in or to such photos and videos. I further consent to Bright Beginnings Academy, LLC using such photos, videos, and any related materials which include my image and/or likeness, at any time, in any manner, edited or unedited, and in any form, including but not limited to broadcast, print, electronic, and social media, for publicity, advertising, and any other business purposes (collectively, "Uses, Media, and Materials"). I understand that I will not receive compensation for the use of my image and likeness, and that I may not be informed in advance of the specific use of my image and/or likeness.

I acknowledge that I have no right to review or approve any Uses, Media, or Materials containing my image or likeness. I acknowledge that Bright Beginnings Academy, LLC are relying on this Photo/Video Release when expending resources producing Uses, Media, and Materials with my image and/or likeness, and my consent hereunder is irrevocable as to any existing Uses, Media, and Materials at the time of my
revocation of the Photo/Video Release. To the fullest extent permitted by law, I voluntarily and irrevocably agree that none of Bright Beginnings Academy, LLC, or any of their officers, shareholders, employees, or agents shall have any liability for any claim, damage, injury, or expense, of any nature whatsoever, arising out of or relating to the Uses, Media, or Materials.

I have read, and I understand, this entire Photo/Video Release.

_____ _____

Signature Printed Name

_____

Date

Security Camera Authorization

I understand that Bright Beginnings Academy has installed security cameras in the school building and around the outside perimeter of the building. I/We also understand that while attending Bright Beginnings Academy my/our child may be videotaped by camera.

I/we recognize that I/we may also be videotaped by a security camera while at or around the school premises. I/we will notify each person listed on the application for admission and may be also taped while at or around the school.

Security camera video footage will be used and/or released solely for safety and security purposes.

Parent or Guardian Signature Date

Parent or Guardian Signature. Date

Bright Beginnings Academy®

Parent-Provided Meals and Snacks Authorization Form

Child's Name: _____
Classroom: _____
Parent/Guardian Name: _____

I am **choosing to provide my child's meals and/or snacks from home**.

- [ ] Breakfast
- [ ] Lunch
- [ ] Morning Snack
- [ ] Afternoon Snack

I **understand that Bright Beginnings Academy® is not responsible for the nutritional value** of the food provided from home or for ensuring it meets my child's daily food requirements.

I understand that **if I provide a meal but not a snack**, Bright Beginnings Academy® will provide a snack as part of the regular food program.

I acknowledge that all food brought from home must follow the center's guidelines on allergies, safe food handling, and storage. No food may be shared between children.

Parent/Guardian Signature: _____
Date: _____

Staff Signature: _____
Date Received: _____

Bright Beginnings Academy

Illness Policy Acknowledgment Form

To ensure the health and safety of all children and staff, Bright Beginnings Academy requires that parents do not bring their child to school if they are exhibiting symptoms of illness. This includes, but is not limited to:

- Diarrhea
- Vomiting
- Fever
- Cough or cold symptoms
- Flu
- Pink eye
- Rash of unknown origin
- Ear infections
- Strep throat
- RSV
- Head lice
- Hand, Foot, and Mouth Disease

By signing below, I acknowledge and agree to the following:
- I will not bring my child to Bright Beginnings Academy if they exhibit any of the symptoms listed above.
- If my child is sent home due to illness, they must be symptom-free for at least 24 hours without the use of medication before returning.
- I understand that some illnesses may require a doctor's clearance before my child is allowed to return to school.

Parent/Guardian Name: _____

Child's Name: _____

Signature: _____

Date: _____

Bright Beginnings Academy

Late Pick-Up Policy Acknowledgment Form

There will be a late pick-up fee charged for each child not picked up by 6:30 p.m., as Bright Beginnings Academy® is required to pay faculty that stay late. As of the date of this Parent Handbook, the late pick-up fees are as follows (subject to change):

- A $25 fee per child will be assessed at 6:30 p.m.
- An additional $20 per child will be charged at 6:45 p.m.
- An additional $20 per child will be charged at 7:00 p.m.
- An additional $20 per child will be charged at 7:15 p.m.
- An additional $20 per child will be charged at 7:30 p.m.
- An additional $20 per child will be charged at 7:45 p.m.

If a parent or guardian has not contacted the school by 7:45 p.m., we are required to inform the proper authorities. From this point on, the children will be in the care of the authorities notified.

Fees for late pick-up are automatically charged to your child's account and are payable immediately. If not paid, the child will not be readmitted to the program. Consistent lateness will be cause for a child's dismissal from Bright Beginnings Academy®.

The parent or guardian present at the time of late pick-up will be required to sign an additional Late Pick-Up Occurrence Form for each instance of tardiness. This form documents the time of pick-up and the fee assessed. Refusal to sign does not waive the fee.

Parent/Guardian Name: _____

Child's Name: _____

Signature: _____

Date: _____

Bright Beginnings Academy

Late Payment / NSF Funds Acknowledgment Form

Monthly Tuition Payment Terms:
If tuition is not paid by the close of business on the first day of each month, an overdue payment fee of $50 will be assessed and is immediately due and payable. If monthly tuition fees (including any applicable late fees) are not received at the school by the 10th of the month, the child will not be readmitted to the program. If the School is compelled to take legal action to collect unpaid tuition, Parents agree to pay the school's reasonable costs of collection, including, but not limited to, attorneys' fees and costs.

Bi-Weekly Tuition Payment Terms:
For bi-weekly tuition that is not paid by the due date, a late fee of $50 will be assessed at the close of business on the day the payment is due. Payment is immediately due and payable. If bi-weekly tuition fees (including any applicable late fees) are not received at the school by the Thursday of the week due, the child will not be readmitted to the program. If the School is compelled to take legal action to collect unpaid tuition, Parents agree to pay the school's reasonable costs of collection, including, but not limited to, attorneys' fees and costs.

NSF (Non-Sufficient Funds) Policy:
An NSF fee of $35 will be assessed for any returned or declined payments, whether for monthly or bi-weekly tuition. After two NSF charges, all future payments must be made by cashier's check unless otherwise approved by school administration.

Parent/Guardian Name: _____

Child's Name: _____

Signature: _____

Date: _____