REGISTRATION FALL 2017

If you desire to enroll your child for the fall of 2017 please return the completed forms and registration fee to the Ridge Kids ECP office. To be place in a three year old class, your child needs to be potty trained.

REGISTRATION FEE:

$100.00 (Non-refundable, due at time of registration)

SUPPLY FEE: (Due with September's tuition)

$65.00 – 2 and 3 year olds who attend 2 days a week
$80.00 – 2 and 3 year olds who attend 3 days a week
$100.00 -- Pre-K classes who attend 3 days a week

TUITION RATES:

2 Year Olds 9:00 – 2:30

Number of Days	Price
2 days a week	$195.00 per month
3 days a week	$255.00 per month

3 Year Olds 9:00 – 2:30

Number of Days	Price
2 days a week	$195.00 per month
3 days a week	$255.00 per month

Pre-K 4's and Pre-K 5's 9:00 – 2:30

Number of Days	Price
3 days a week	$255.00 per month

Ridge Kids Early Childhood
Enrollment Information Fall 2017

Name	Date of Birth	M or F
Address	City	Zip Code
Home Phone	Email	
Parent/Guardian Name	Work Number	Cell Number
Parent/Guardian Name	Work Number	Cell Number
Person and Phone number to call in case of Emergency if parent cannot be reached:		
I authorize ECP to allow my child to leave the program ONLY with the following persons, along with the persons listed above: / / /		
Do you have a church home? Y or N If so, where		

Authorization for Emergency Medical Attention

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

Name of Physician or Hospital : Address: Phone:

My Child is allergic to the following medication: _____

I give consent to Walnut Ridge Baptist Church and Ridge Kids Early Childhood to secure any and all necessary emergency medical care for my child.

Parent or Guardian Signature: _____ Date_____

Parent Name: _____Drivers License Number: _____

Notary of Public : _____Date:_____

Notary Seal:_____

Child's Name: _____Birthday: _____

I give Ridge Kids my permission to take snap shots and / or videos during the school year (2017-2018) yes or no

My child may participate in water table play . . . . . yes or no

My child does NOT have food allergies however I choose for my child NOT to have the following items at ECP.

_____

My child has allergies that ECP needs to be aware of . . . . . yes or no
If Yes, there is an attached form that needs to be signed by you and the physician. Only if it a FOOD allergy

My child has medical issues that the ECP needs to be aware of . . . . . yes or no
If yes, please explain _____

Other than food , my child is allergic to the following : _____

I give Ridge Kids my permission to put my child's picture on Ridge Kids Face Book Page . . . . . yes or no

I submit that all information provided on this form is correct and to the best of my knowledge. If any of the information becomes incorrect, I understand it is my responsibility to provide ECP with correct information in writing as soon as possible. I understand that the completion of this form and payment of the registration fee guarantees placement of my child in ECP. I also understand that the registration /supply fee is non – refundable.

_____ _____
Parent/Guardian Signature Date

Days Enrolled: circle one **Tuesday/Thursday** **Tues/Weds/ Thurs**

Ridge Kids Office Use Only
Age Group;_____(all Three year olds must be potty trained)
Registration Fee:_____Supply Fee _____

Date of Admission_____

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

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following allergens: _____

THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

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

OR A COMBINATION of symptoms from different body areas.

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

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

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

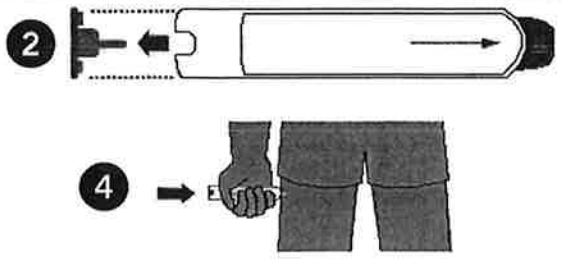
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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

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

EPIPEN® AUTO-INJECTOR DIRECTIONS

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



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

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

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

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

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

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

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

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

Ridge Kids
Doctor Statement

Name of Child: _____Date of Birth_____

Admission Requirements: The following must be presented when your child is admitted to Ridge Kids for Admission in the Fall 2017

Doctor's Statement: I have examined the above named child and find that he/she is physically able to take part in the Early Childhood Program

_____

Physician's Signature Date

Please attach a copy of your child's updated immunization records

Hearing and Vision Screening : State requires for all students who are 4 years old by September 1, 2017 .

Hearing

Ear	1000HZ	2000HZ	4000HZ
Right			
Left			

Pass/Rescreen/Refer Screened by: _____

Vision R20/_____L20/____

Glasses R20/_____L20/_____

Pass/Rescreen/Refer Screened by:_____

Signature: Physician or Health Personnel _____Date_____

Signature: Staff making handwritten copy of record: _____Date_____