



First Fulshear Early Learning Center

2024-2025 School year fees

Tuition is collected September through May. Classes start in late August TBA

Preschool Tuition Ages 2-4

8:45-2:45	T/TH	\$325.00/month
8:45-2:45	MWF	\$460.00/month
8:45-2:45	5 days	\$725/month

Kinder-Bridge age 5

8:45-2:45	5 days only	\$725/month
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Preschool early care

7-8:45	T/Th	\$100/month
7-8:45	MWF	\$150.00/month
7-8:45	5 days	\$250.00/month

*Children must be enrolled in regular care to qualify for early or late care.

Preschool after school care

2:45-6:00	T/Th	\$125.00/month
2:45-6:00	MWF	\$175.00/month
2:45-6:00	5 days	\$300.00/month

Registration Fees

T/Th-	\$150.00
MWF-	\$175.00
5 days-	\$275.00

Semester supply fees

T/Th-	\$100.00 per semester
MWF-	\$150.00 per semester
5 days-	\$200.00 per semester

Elementary after school care Morgan Elementary only

Kindergarten-5 th grade	M-F	3:00-6:00 pm	\$300.00/month
Registration fee	\$100	Supply fee	\$60/semester

Payment and registration contract

We offer a Sibling discount of 10% off second child only in our preschool program for regular tuition, not before or after school care.

We reserve the right to cancel a class if minimum enrollment is not met. Late pick up fee \$1.00 per minute. Children may not be dropped off before 8:45 unless enrolled in early care. Kids may not be picked up after 2:45 unless enrolled in late care.

We generally follow LCISD calendar for holidays and school closings, however you will receive an official FFELC calendar in August 2024.

There are not deductions to tuition for holidays, emergency closures or absences unless such policies have been adopted such as the covid/pandemic guidelines.

Payment Agreement Contract:

I understand that my child's first tuition payment is due on September 1st. If I register but do not give notice that my child will not be attending by August 1st, I will be responsible for September tuition.

I understand that tuition is due by the 5th of every month or a late fee will be accessed of \$15.00 for late tuition.

I understand that I must submit a 30 day notice if I decide to withdraw my child from the school.

I understand that all registration fees are non-refundable for any reason.

Payments can be made by auto draft from a bank account or by credit card (2.75% fee for credit cards only)

Child's name _____

Parent's Signature _____ date _____

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: Fulshear Early Learning Center		Director's Name: Jill Samoff	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian
Child's Home Address:		Date of Admission: 08/21/2024	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian <i>(if different from the child's)</i> :	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
In case of an emergency, 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). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
2. Field Trips:
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.
Comments: <div style="border: 1px solid black; padding: 5px; min-height: 100px;"> <p>We do not take children on field trips</p> </div>

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)	
Haemophilus Influenza Type b	2 months (first dose)	
	4 months (second dose)	
Pneumococcal	4 months (first dose)	
	6 months (second 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 6 to 18 months after the first dose.	

Please provide a current copy of immunizations

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

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

- Yes No

Do you want your child to wear a life jacket while in or near a swimming pool?

- Yes No

4. Receipt of Written Operational Policies:

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

- | | |
|---|---|
| <input checked="" type="checkbox"/> Discipline and guidance | <input checked="" type="checkbox"/> Procedures for release of children |
| <input checked="" type="checkbox"/> Suspension and expulsion | <input checked="" type="checkbox"/> Illness and exclusion criteria |
| <input checked="" type="checkbox"/> Emergency plans | <input checked="" type="checkbox"/> Procedures for dispensing medications |
| <input checked="" type="checkbox"/> Procedures for conducting health checks | <input checked="" type="checkbox"/> Immunization requirements for children |
| <input checked="" type="checkbox"/> Safe sleep | <input checked="" type="checkbox"/> Meals and food service practices |
| <input checked="" type="checkbox"/> Procedures for parents to discuss concerns with the director | <input checked="" type="checkbox"/> Procedures to visit the center without securing prior approval |
| <input checked="" type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input checked="" type="checkbox"/> Procedures for supporting inclusive services |
| <input checked="" type="checkbox"/> Procedures for parents to participate in operation activities | <input checked="" type="checkbox"/> 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

See attached page

Provider's Guide to Parent's Rights

Senate Bill 1098 from the 88th Legislative Regular Session added Section 42.04271 to the Human Resources Code and states that a parent or guardian of a child at a child care facility has the right to:

- Enter and examine the child-care facility during its hours of operation and without advance notice;
- File a complaint against the child care facility;
- Review the child care facility's publicly accessible records;
- Review the child-care facility's written records concerning the parent's or guardian's child;
- Receive inspection reports and information about how to access the child care facility's online compliance history;
- Have the facility comply with a court order that prevents another parent or guardian from visiting or removing the child;
- Be given the contact information for the child care facility's local Child Care Regulation office;
- Inspect any video recordings of an alleged incident of abuse or neglect involving their child provided that:
 - Video recordings of the alleged incident are available;
 - The parent or guardian does not retain any part of the video depicting a child that is not their own; and
 - The parent or guardian of any other child in the video receives prior notice from the facility;
- Obtain a copy of the facility's policies and procedures handbook;
- Review the facility's staff training records and any in-house training curriculum; and
- Exercise these rights without receiving retaliatory action by the facility.

Required Notifications

- The child care facility must provide written notice to the parent or guardian of any other child captured in a video before allowing a parent to inspect a recording.
- The child care facility must provide a parent or guardian with a written copy of the rights no later than the child's first day at the facility.

Helpful Tips

Since a parent may perceive an action taken by a child care facility as retaliatory, keep in mind:

- Documentation is essential in supporting your actions; and
- Follow the suspension and expulsion policy outlined in your operational policies and update your policy, if needed.

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

- | | |
|--|---|
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Limitations or restrictions on child's activities |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Reasonable accommodations or modifications |
| <input type="checkbox"/> Existing illness | <input type="checkbox"/> Adaptive equipment (<i>include instructions below</i>) |
| <input type="checkbox"/> Previous serious illness | <input type="checkbox"/> Symptoms or indications of complications |
| <input type="checkbox"/> Injuries and hospitalizations (<i>past 12 months</i>) | <input type="checkbox"/> Medications prescribed for continuous long-term use |
| <input type="checkbox"/> Other: _____ | |

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 <https://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 his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

None

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	Phone No.
Name of Emergency Care Facility	Address	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				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> 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 that he or she is 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 _____

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: Not required in our county

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 _____

Directory, email, photo and social media release

Child's name _____

Parent's email address that they want to receive all school emails
to: _____

Please circle one:

I give

I do not give

First Fulshear ELC permission to share my child's photo to our class only ClassTag app. I understand that if I do not give permission, I will not see any pictures that my child's teacher takes for their class.

I give

I do not give

First Fulshear permission to share my child's photo (no names) on the school and or church social media posts.

I give

I do not give

First Fulshear permission to share my name, address, email address and phone number with other parents in a class directory. I understand that if I do not give consent, only my child's name will be printed in the directory.

I wish to share only this info in the directory _____

Parent
signature _____ date _____

Student/family Information

Child's name _____ Date of birth _____

Address _____

Mom's Name _____ cell # _____

Mom's email address _____

Mom's occupation _____

Dad's Name _____ cell # _____

Dad's email address _____

Dad's occupation _____

Does child live with both parents in the same house? Yes No

If in separate homes, please explain how custody

works _____

Siblings in the home and

ages _____

Pets? _____

Child's

fears? _____

What helps calm your

child? _____

Has your child ever been in preschool before? _____ if yes,
where? _____

Does your child require specific special needs in the classroom? If yes, please
explain _____

Is your child under the supervision of a doctor or specialist for any social emotional or developmental
issue that we should know about to better assist your child in the classroom?

Any medical issues we should be aware
of? _____

Allergies? _____

Sleep habits or issues we should know
about? _____

Any recent changes that we should know about that may cause your child stress or
anxiety? _____

Anything else we should know about your
child? _____

Do you have a church home? _____



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

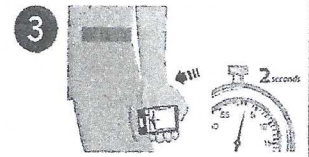
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



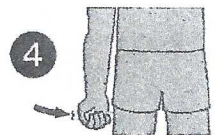
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



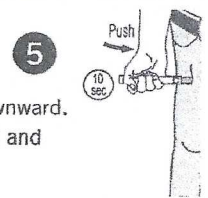
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.



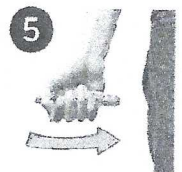
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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.



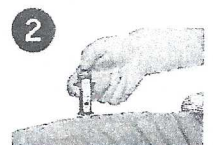
HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

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: _____

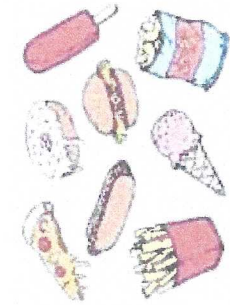
NAME/RELATIONSHIP: _____ PHONE: _____

Our school promotes healthy eating to provide the best environment for learning and growing. We are a state licensed facility, so we are required that children are provided healthy and nutritious snacks and lunches. We have given some suggestions for healthy foods on the left. The **NO** foods are foods that we will not allow children to bring to school for lunch or snack. Thanks!

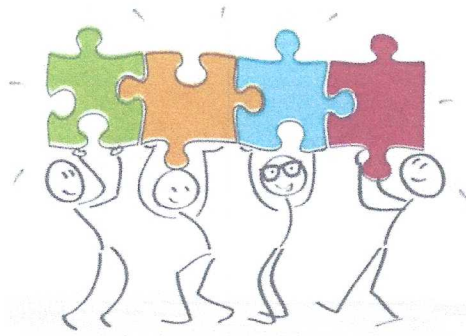
According to the American Heart Association kids age 2-18 should have less than 25g of added sugars daily. When it comes to carbs the daily amount is 150g.

Sodium: Ages 1-3 1500mg or less per day.

Ages 4-8 1900mg or less per day.



Yes Foods	No Foods
<ul style="list-style-type: none"> Hummus Yogurt Cheese/String Cheese Babybel Cheese Fruit (bite size) Veggies (bite size) Bars Unsweetened Applesauce Dried fruit Freeze dried fruit Goldfish Cheeze Its Green Pea snack crisps Made Good products Crackers 	<ul style="list-style-type: none"> Lunchables Candy Cookies Fruit Snacks Chips Rice Krispy treats Gum Donuts Pop Tarts Jello Pudding Sugary drinks



Working Together, A parent commitment to our school (please keep for your records)

We are so excited that you have chosen to register your child at First Fulshear Preschool for your child's spiritual, educational and emotional needs. When we work together, we have the best outcome for each child. We have made commitments as educators to care for each child individually and do all that we can to help them be successful. We are asking our parents to commit toward the common goal.

I commit to bring my child to school on time every day, understanding that the most important learning times are at the beginning of my child's day and it also allows my child time to transition into his/her day. Drop off times 8:45am-9:00am. I understand that if I arrive after 9am, I will not be able to walk my child in. I also understand that if I bring my child after 9:15 without prior Director approval, my child will not be allowed to attend. I will inform the Director of any appointments that make my child late to school.

I commit to pick my child up on time every day. No later than 2:45 unless signed up for after care. I understand late fees will apply for all children picked up late.

I commit to read all communication through email, the class tag app, or through written notes in my child's folder. I will respond as needed.

I commit to help my child finish any work that has been sent home uncompleted.

I commit to partner with my child's teacher on any behavioral or developmental issues and if necessary, meet with the Teacher and Director to come up with solutions.

I commit to work on any educational extras that my teacher may send home that will help my child be successful.

I commit to pack a healthy lunch (brain food) and 2 snacks every day as well as pack a refillable water bottle. I commit to follow the food guidelines I have been given and not bring items the school does not allow. If my child does after care, I understand I will need to bring extra snacks.

I commit to wash my child's nap mat every week and return it in the Ziploc bag provided.

I commit to send my child in tennis shoes and weather appropriate clothing daily.

I commit to not allow my child to bring outside toys or other items that may be a distraction.