2020-2021

LEAP/Extended Day Program
ENROLLMENT APPLICATION

In accordance with the Arizona Department of Health Services the student to teacher ratio is 1 to 20. In an effort to keep track of the LEAP/Extended Day Program ratio please complete the information below.

Child's Name	Grade	Teacher's Name

Select the School Your Child Attends:

- ◯ Estrella Mountain ES
- ◯ Freedom ES
- ◯ Las Brisas Academy
- ◯ Liberty ES
- ◯ Rainbow Valley ES
- ◯ Westar ES

Does your child require special services or accommodations? ◯ Yes ◯ No

If Yes, please specify: _____

Which program will your child be attending?

- ☐ AM only $80/month
- ☐ PM only $210/month
- ☐ Both AM & PM $235/month
- ☐ Early Release Only $60
- ☐ 10 USE Occasional Block $135 – Each session = 1 use

Please Check:	Monday	Tuesday	Wednesday	Thursday	Friday
Morning:	☐	☐	☐	☐	☐
Afternoon:	☐	☐	☐	☐	☐

$30 Annual Registration Fee Due per Child

I understand:

- ☐ A written notification must be given to the District Office at least two weeks in advance to change program usage or withdraw from the program.
- ☐ Additional fees are required for non school days ie. breaks and inservice days

Parent/Guardian Name (Printed) _____ E-mail Address _____

Parent/Guardian Signature _____ Date _____

LIBERTY ELEMENTARY SCHOOL DISTRICT No. 25
19871 West Fremont Road ● Buckeye, AZ 85326 ● Phone (623) 474-6600 ● Fax (623) 474-6629

CDC/SGH# or name:_____

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Parent or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):_____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	■ **No** ☐ **Yes**
Is child usually susceptible to infections and if so, what precautions need to be taken? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Is child subject to convulsions and what should be our procedure if one occurs? **If yes**, specify procedure:	☐ **No** ☐ **Yes**
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **If yes**, list precautions:	☐ **No** ☐ **Yes**
Additional comments:	
Other special instructions:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**

Arizona Department of Health Services
Bureau of Child Care Licensing

MEDICATION CONSENT FORM

First & Last Name of **CHILD**:			
Type/Name of Medication:	Prescription #:	Dosage**:**	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of authorization:	Signature (parent/guardian):		

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

_____

_____

* Injections: Attach health care provider's written authorization.

****

FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	☐	☐
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?	☐	☐
Is the full name of the child on the container?	☐	☐
Is the prescription or over-the-counter medication current?	☐	☐
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?	☐	☐

Staff initials:_____

Please use the second page to document administration of the medication.

Name of Child:

DATE	NAME OF MEDICATION	RX#	DOSE	TIME	FULL SIGNATURE of AUTHORIZED STAFF PERSON

LEAP/Extended Day Program
Media Consent Form

This Media Consent F0rm allows Liberty Elementary School District to videotape and photograph your child with his/her teacher this school year. The purpose of the video and/or photograph is to provide a resource of reflection.

Child's Name	Grade	Teacher's Name

Web/Internet Publishing

1. Image - Make one selection only:

☐ I will allow my child's image (including photo- graph and video) to be published on the school and/or District website.

☐ I will ***not allow*** my child's image to be published on the school and/or District website

2. Schoolwork– Make one selection only:

☐ I will allow my child's schoolwork (including photograph and video) to be published on the school and/or District website.

☐ I will ***not allow*** my child's schoolwork to be published on the school and/or District website

3. District Publishing (for use by the District) - Make one selection only:

☐ I will allow my child's image (photo, audio and video), to be used by the District for promotional purposes. Photos may be published in the form of print, electronic presentations or video materials created for District use and/or community-wide distribution.

☐ I will ***not allow*** my child's image to be used by the District for promotional pur- poses.

Please read, sign below and return to your child's school. Thank you.

I understand that, in the event the school or district uses photographs and/or video footage of my child, that no compensation will be made to me for this use. I also understand that this form is applicable only for the duration of my child's enrollment at the school mentioned below and that I will be required to complete a new form to make changes or when my child enters a new school. I acknowledge by my signature below that I understand the above stated information.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

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LEAP/Extended Day Program
Movie Consent Form

On occasion LEAP Extended Day will be showing PG rated movies that are age appropriate. Movies to be shown on the given day will be posted at the sign-in desk along with the movie rating. The below form gives your child permission to view PG rated movies. If you turn in the form below and decide there is a movie you do not want your child to watch, please notify a staff member. We will find an alternative activity for your child to do during this time.

I _____ give permission for my child(ren)

_____
- ☐ Can watch PG movies.
- ☐ Cannot watch PG movies

_____
- ☐ Can watch PG movies.
- ☐ Cannot watch PG movies

_____
- ☐ Can watch PG movies.
- ☐ Cannot watch PG movies

_____
- ☐ Can watch PG movies.
- ☐ Cannot watch PG movies

_____
Parent/Guardian Name (Printed)

_____ _____
Parent/Guardian Signature Date

LEAP/ Extended Day Program
ACKNOWLEDGEMENTS AND VERIFICATIONS
This form must be returned to your LEAP Site within 10 days.

School/LEAP SITE _____ **Date** _____

Child's Name (Print) _____

Child's Name (Print) _____

Child's Name (Print) _____

Child's Name (Print) _____

Parent/Guardian's Name (Print) _____

By signing below you acknowledge and verify that you have received and taken the responsibility to review the LEAP/Extended Day Program Parent Handbook. The procedures were designed to create an orderly environment that is safe for all children and the staff. The rules are reasonable and fair and they are the same at all of the LEAP/Extended Day sites. We ask that you read this handbook carefully.

Please note: Federal privacy laws prohibit LEAP/Extended Day staff from naming students involved in disciplinary actions and from revealing the consequences of those actions to the parents of other students.

Signature of Parent/Guardian _____

Signature of Child _____

Signature of Child _____

Signature of Child _____

Signature of Child _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

BEST OF CARE

This confidential form is to help your child care provider support the growth and development of your child while creating a safe, stable and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH

PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PROVIDER/CENTER NAME

Has your child attended child care in the past? ☐ Yes ☐ No

If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

What did you like most about your child's previous child care setting?

What did you like least?

Other comments:

What is important to you about your child's care?

Who is important to your child?

Does your child prefer to play alone or with other children? ☐ Alone ☐ Other children

Does your child have a favorite toy or comfort object? ☐ Yes ☐ No

If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? ☐ Yes ☐ No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

See reverse for EOE/ADA/LEP/GINA disclosures

CHILD'S NAME

Special things you say or do to comfort your child are?

How do you know when your child is:
Happy?
Sad?
Mad?
Tired?
Other?

How does your child react when:
Something unexpected happens?

Something happens he/she doesn't like?

He/She is scared?

Other?

Does your child have any health issues? ☐ Yes ☐ No
If yes, please explain:

Does your child have any other special needs? ☐ Yes ☐ No
If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? ☐ Yes ☐ No
If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship for your child?

☐ Parent/Guardian declined to complete

Parent/Guardian Signature

Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.