INtrinsic
Scholars Academy

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ENROLLMENT FORM

_____
Entrance Date (mm/dd/yyyy) Birth date (mm/dd/yyyy)

_____
Child's Name (last, first, middle initial)

_____
Child's Nickname Gender Age

_____
Home Address (Street Address, City, State and Zip Code)

(_____)_____
Home Telephone Number Child's Primary Language

_____
School Attending (school age children only)

(_____)_____(_____)_____
Mother's or Guardian's Cell Telephone Number Father's Cell Telephone Number

_____(_____)_____
Father's or Guardian's Name/Home Address/Telephone Number, if different from child's

_____(_____)_____
Place of Employment/Address of Employment/Business Number with extension

_____(_____)_____
Mother's Name/Home Address/Telephone Number, if different from child's

_____(_____)_____
Place of Employment/Address of Employment/Business Number with extension

Regular Care Arrangements: Lives with Both Parents Mother Father Other:

_____
Are there any custody arrangements for your child? _____
If yes, please describe:

_____
(A court order with supporting documentation describing custody arrangements and restrictions must be provided.)

_____
Child's Legal Guardian(s) Both Parents Mother Father Other

Pick up/Drop off Authorizations: My child may be released to the person(s) signing this agreement or to the following:

Name	Address (include complete street address, city, state and zip code)	Telephone	Rel. to child

Emergency Contacts: Persons to contact in case of an emergency when parents cannot be reached. These people are authorized to make medical decisions concerning my child.

Name	Address (include complete street address, city, state and zip code)	Telephone

_____(____)_____
Pediatrician or child's primary health care source name Telephone number

_____(____)_____
Dentist name Telephone number

Does your child have any allergies or food restrictions?_____ If yes, please describe and attach care plan:

_____

_____
Does your child have any diagnosed special needs, medical or mental conditions? _____ If yes, please describe:

_____

_____
Are your child's activities restricted by any special needs, developmental disabilities, medical or other conditions? _____ If yes, please describe: _____

_____
The following special accommodation(s) may be required to most effectively meet my child's needs while at this school.

(circle one) NONE YES

_____

_____
My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns unmentioned above:

(circle one) NONE YES

_____

_____

Medical Insurance Information
Insurance Carrier _____ Insured's Name _____

Primary Care Physician Name _____ Telephone (____)_____

ID or Policy # _____Member Service Number (____)_____

EMERGENCY MEDICAL AUTHORIZATION

Should my child suffer an injury or illness while in the care of INtrinsic Scholars Academy and the facility is unable to contact me/us immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I/We agree to keep the facility informed of changes in telephone numbers, etc. where I/We can be reached. The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child. Permission is granted to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical and transportation expenses incurred.

In consideration of the registration of my child, I release INtrinsic Scholars Academy and their related companies, directors, officers, employees and agents, from any claims, losses, damages or costs (including attorneys' fees) caused by or arising from my child's registration, use of the facility, or participation in the programs and activities conducted by the program other than to the extent caused by the negligent or willful misconduct of the program and their related companies, directors, officers, employees and agents.

Release And Waiver Of Liability For Administering An Asthma Inhaler To Children With Asthma

(Release) between INtrinsic Scholars Academyand (parent(s)/guardian(s) name) who are the Parent(s)/Guardian(s) of (child's name). (parent(s)/guardian(s) name) have requested INtrinsic Scholars Academy provide emergency treatment for their child at INtrinsic Scholars Academy and take certain actions described in the child's "Asthma Care Plan" (Authorization), which is attached to this Release and is hereby incorporated by reference.

The parties agree that (parent(s)/guardian(s) name)releases INtrinsic Scholars Academy and its officers, employees or agents from all liability which may arise as a result of INtrinsic Scholars Academy administering asthma treatment or following the directions in the Authorization (including any additional physician's instructions or clarifications) as long as such employees or agents exercise reasonable care in taking such actions. (parent(s)/guardian(s) name) also releases INtrinsic Scholars Academy and its officers, employees or agents from all liability arising out of the use of any materials and/or equipment supplied by the parent(s)/guardian(s) in connection with the asthma treatment as long as such employees or agents exercise reasonable care in the use of such materials or equipment.

This Release shall be governed by the laws of the State of _____, where INtrinsic Scholars Academy is located.

Parent Signature(s) _____ Date _____

FAMILY AGREEMENT

PLEASE CHECK ALL THAT APPLY:

___ The school agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

___ TRANSPORTATION: I hereby ____ give ____ do not give – consent for my child to be transported and supervised by the operation's employees. ___ for emergency care

___ FIELD TRIPS: I hereby ____ give ____ do not give – my consent for my child to participate in Field Trips:

___ WATER ACTIVITIES: I hereby ____ give ____ do not give – my consent for my child to participate in Water Activities: ___ sprinkler play ___ splashing/wading pools ___ swimming pools water ___ table play

___ VIDEO/PHOTOGRAPHY: I give permission for my child to be photographed and videotaped for use by or on behalf of the facility for educational, training, curriculum, marketing and similar purposes. ___ Yes ___ No

___ DAYS/HOURS: INtrinsic Scholars Academy agrees to provide educational services for my child
on: (circle all that apply) Monday Tuesday Wednesday Thursday Friday
from _____a.m. to _____p.m..

___ MEALS: The program will provide a lunch and snacks which are in compliance with United States Department of Agriculture guidelines. I agree to provide substitute meals which meet USDA guidelines in the event my child has medical reasons for a substitution and a physician's statement.

___ MEDICATION AUTHORIZATION: Before any medication is dispensed to my child, I will provide a written authorization, which includes: date, name of child, name of medication, prescription number, if any; dosage; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

___ AUTHORIZATION TO DISPENSE EXTERNAL PREPARATIONS: I/we authorize INtrinsic Scholars Academy employees permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes
_____ Band-aids
_____ Neosporin or similar ointment
_____ Bactine or similar first aid spray
_____ Sunscreen
_____ Insect Repellent
_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
_____ Baby Powder
Other (please specify) _____

___ SAFETY: My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

___ RECORDS: I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g. telephone numbers, work location, emergency contacts, child's physician, child's health status, and immunization records, etc.

___ INCIDENT REPORTS: The school agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, exposure to communicable disease, which include my child.

___ CONFERENCES/PROGRESS REPORTS: I am advised that the school will notify me of my child's progress, issues relating to his/her care and any individual special needs

___ PARENT INVOLVEMENT: INtrinsic Scholars Academy encourages parents to volunteer and attend all functions. I will receive monthly communication regarding these events and opportunities.
___ NO EMPLOYMENT: I will not solicit, employ or enter into any contract with any employee of INtrinsic Scholars Academy to perform child care or similar services under any circumstances without the express consent of Intrinsic. If I employ or contract with any employee of INtrinsic Scholars Academy or person who within one year of the date of such employing or contracting was employed or under contract with Intrinsic Scholars Academy, I will pay the School a placement fee of $5,000.
___ PARENT HANDBOOK: I have received, reviewed and understand the Parent Handbook and related information concerning the school and the educational services provided by Intrinsic Scholars Academy I will use the program in accordance with the terms of the Parent Handbook and the policies and procedures made available at the facility. Use of the facility and the services may be denied in the event I do not comply with the terms of this Agreement, or when determined by the administration to be in the best interests of my child or the children enrolled in the afterschool program. The availability of these services are subject to change at any time.
___ REGISTRATION AND PAYMENTS: Registration must be fully completed prior to my child attending the afterschool program. Where applicable, all registration fees and/or tuition fees must be paid in connection with the registration of my child and use of the program.

RECEIPT OF WRITTEN OPERATIONAL POLICIES:
I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

Signature (Parent/Guardian) _____

Date _____

Signature (Parent/Guardian) _____

Date _____

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Infant Feeding and Care Plan

This information is confidential.

Child's Name _____

Date _____

Birthdate_____

Does your child take a bottle?	Yes	No
Is the bottle warmed?	Yes	No
Does your child hold own bottle?	Yes	No
Can your child feed self?	Yes	No

Does your child eat:

Strained Foods	Whole Milk
Baby Foods	Table Food
Formula	Other

What type formula used? _____
Amount of formula to be given? _____
Updated amounts of formula? _____Date _____
_____ Date _____
_____ Date _____
Does your child take a pacifier? Yes No
When? _____
Food likes _____ Food dislike_____
Allergies- including any premixed formula _____

Schedule

Breakfast _____
Approximate Time Types and approximate amount of food

Lunch _____
Approximate Time Types and approximate amount of food

Dinner _____
Approximate Time Types and approximate amount of food

Morning Nap _____ Afternoon Nap _____
Approximate Time Approximate Time

Instructions for the introduction of solid foods _____

_____

_____
As needed, please list updated instructions regarding adding new foods or other dietary changes.

_____

_____

Has your child had any feeding problems? (Please describe in detail) _____

_____

Is your child: __ breast fed __ bottle fed __ weaned
Supplemental infant information:

Describe your child's present napping pattern _____

_____
Does your child usually cry when going to sleep? __ No __ Yes
Does your child cry when waking? __ No __ Yes
Do you have any special ways of helping your child go to sleep?
_____

_____

Does your child have any special needs?_____

_____
_____
_____
Does your child have any allergies? __ No __ Yes Describe: _____
Please have your pediatrician submit a care plan and update it every 90 days.

Has your child had a serious illness? __ No __ Yes Describe: _____
_____
Has your child had any surgical procedures? __ No __ Yes Describe:
_____

Does your child take any medications on a regular basis? (Please give details)_____
_____
_____
Please indicate which of the following diseases your child has previously experienced:

__ Whooping Cough __ Pneumonia __ Mumps

__ Chicken Pox __ Measles (10 day) __ Allergies

__ Eczema __ High Temperature (Over 103)__ Neurological

__ Roseola (24 Hr. Measles) __ Rubella (3 day-German Measles) __ Recurrent Ear Infections

__ Other _____
Please take a moment to tell us anything else that would help us to provide the best care for your child.
_____

_____

Food Allergy Action Plan

Student Name _____ Date of Birth _____
To be completed by a physician.

TREATMENT **Symptoms:**	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
If a food allergen has been ingested, but *no symptoms*:	Epinephrine Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	Epinephrine Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	Epinephrine Antihistamine
Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine Antihistamine
Other† _____	Epinephrine Antihistamine
If reaction is progressing (several of the above areas affected), give:	Epinephrine Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE
Epinephrine: inject intramuscularly (circle one)
EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
Antihistamine: medication/dose/route
give_____
Other: medication/dose/route
give_____

EMERGENCY CALLS
1. Call 911 (or EMS: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts: Name/Relationship Phone Number(s)

_____

_____

Even if parent/guardian cannot be reached, do not hesitate to medicate or take the child to a medical facility!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____

Asthma Care Plan

Student Name _____ Date of Birth _____

Parent(s) or Guardian(s)
Name:_____
Emergency Phone Numbers *(see emergency contact information for alternate contacts if parents are unavailable)*:

Mother: _____ Father: _____

Physician's Name: _____ Phone: _____

Asthma Specialist's Name: _____ Phone: _____
Known triggers for this child's asthma *(circle all that apply)*:

colds	exercise	tree	pollens	dust	strong odors
excitement	weather changes	smoke	animals	grass	flowers
mold	room deodorizers		foods (specify):		
other (specify):					

Activities for which this child has needed special attention in the past *(circle all that apply)***:**

Outdoors	*Indoors*
field trip to see animals	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening	sitting on carpets
jumping in leaves	pet care
outdoors on cold or windy days	recent pesticide application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify):	

Can this child use a flowmeter to monitor need for medication in child care: YES NO
Personal best reading: _____
Reading to give extra doses of medicine: _____
Reading to get medical help: _____

How often has this child needed urgent care from a doctor for an attack of asthma:
In the past 12 months? ____ In the past 3 months? ____

Typical signs and symptoms of the child's asthma episodes *(circle all that apply)*:

face red, pale, or swollen	grunting	breathing faster >50 breaths a min.
sucking in chest/neck	restlessness/agitation	persistent coughing
dark circles under eyes	fatigue	complaints of chest pain/tightness
gray or blue lips/fingernails		difficulty playing, eating, drinking, talking
flaring nostrils, mouth open (panting)		

Medications for routine and emergency treatment of asthma for:

Child's name _____ Date of Birth _____

Name of medication			
When to use (e.g., symptoms, time of day, frequency, etc.)	*routine or emergency*	*routine or emergency*	*routine or emergency*
How to use (e.g., by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc.)			
Amount (dose) of medication			
How soon treatment should start to work			
Expected benefit for the child			
Possible side effects, if any			
Date instructions were last updated by child's doctor	Date: Name of Doctor (print): Doctor's signature:		
Parent's permission to follow this medication plan	Date: Parent's signature:		

Diabetes Health Care Emergency Action Plan

Student Information		
Name:	DOB:	Grade:
Address:		
Father/Guardian:	Phone (home):	Phone (work):
Mother/Guardian:	Phone (home):	Phone (work):
Other Emergency Contacts		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Physician:		Phone:
Hospital:	Transport: | | Parent | | Ambulance | | Other	

Emergency items to be left at school:

[ ] Glucose tablets
[ ] Snacks
[ ] Syringes
[ ] _____

[ ] Blood glucose meter
[ ] Insulin
[ ] _____
[ ] _____

In the event of an insulin reaction, the procedure routinely followed at school is to give some form of sugar such as 1/2 carton of milk followed with crackers and peanut butter, 1/2 cup fruit juice or 1/2 cup non diet soda. If the student is unconscious, "911" is called.

I approve the above health care action plan as written. Yes ___ No ____

Please make the following changes to the health care action plan:

_____

_____

_____

List other additional information or significant special health concerns of this student:

_____

_____

_____

I give permission for emergency blood glucose testing by the school nurse using equipment I have provided. I understand that when the school nurse is not available for emergency blood glucose testing, the parent/guardian will be notified or "911" will be called. Yes _____ No _____

Additional directions regarding blood glucose testing:

_____

_____

Written and submitted by:	_____	_____
	Nurse	Date
Reviewed and signed:	_____	_____
	Parent/guardian	Date
	_____	_____
	Student	Date
	_____	_____
	Physician	Date
To be reviewed	_____	
	Date	

Healthcare plans should be revised according to child's specific needs, at least annually.