

Operation Name RISING STAR ACADEMY		Directors Name Samantha Eades		Date of Admission
Child's Full Name		Child's Date of Birth	Child's Home Phone Number	
Child's Home Address, City & Zip Code				
Mother/Guardian Name		Father/Guardian Name		
Mother's Cell Number	Mother's Work Number	Father's Cell Number	Father's Work Number	
E-mail		E-mail		

*I hereby authorize Rising Star Academy to release my child ONLY to the following persons. List name and phone number for each. Children will only be released to a parent or persons designated by the parent/guardian after ID verification.*

Emergency Contact Full Name:	Cell Number:	Work Number:	Authorized to Pick Up: <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Full Name:	Cell Number:	Work Number:	Authorized to Pick Up: <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Full Name:	Cell Number:	Work Number:	Authorized to Pick Up: <input type="checkbox"/> Yes <input type="checkbox"/> No

*When calling Rising Star Academy to authorize a person other than someone on my child's list of authorized pick-up contacts, I will use the following password to verify my identity and authorization for release, if I am unable to do so in writing.*

**TRANSPORTATION:** I hereby  give  do not give consent for my child to be transported by RSA.  
 for emergency care  on field trips  to and from school

**FIELD TRIPS:** I hereby  give  do not give consent for my child to participate in field trips.

**WATER ACTIVITIES:** I hereby  give  do not give consent for my child to participate in water activities.  
 sprinkler play  splashing/wading  swimming pools  waternable play

**PHOTOGRAPHS:** I hereby  give  do not give consent for my child to be photographed.  
 educational  website  advertising  RSA Facebook

5.  **RECEIPT OF OPERATIONAL POLICIES AVAILABLE ONLY ONLINE,**  
*I acknowledge receipt of the facility's operational policies including those for discipline and guidance.*


6. **I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:**  
 None  Breakfast  Lunch  PM Snack

7. **MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:**  
 MONDAY-FRIDAY  
 6:30-6:30  9:00-3:00  Before school  After School  Before and After School

**VACATION POLICY**

- Each family is entitled to one week of tuition-free vacation time during the calendar year. \*\*
- RSA requires a written notice two weeks in advance when you want to schedule vacation.
- Unscheduled absences, including illnesses, will not be accepted as vacation time.
- Should a family's plans call for them to be away for longer than two weeks during the academic year, you will be responsible for 50% tuition to hold your child's spot.

*I have read and will abide by this policy*

 \_\_\_\_\_

(Parent or Guardian signature) \_\_\_\_\_ Date \_\_\_\_\_

\*\*Our Calendar year is from August to August.

**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:**

*In an event I cannot be reached to make arrangements for emergency medical care, I hereby authorize the person in charge to take my child to:*

<b>Name of Physician:</b>	<b>Address:</b>	<b>Phone:</b>
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**Choose an emergency hospital. Should you prefer your own hospital, you must provide hospital name, address, and phone number.**

<input type="checkbox"/> <b>Christus St. Catherine</b> 701 S. Fry Rd. Katy, TX 77450 (281) 599-5160	<input type="checkbox"/> <b>Memorial Hermann Katy Hospital</b> 23900 Katy Freeway Katy, Texas 77494 (281) 644-7000	<input type="checkbox"/> <b>Hospital name:</b> <b>Address:</b> <b>City, State, Zip:</b> <b>Phone Number:</b>
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**I give consent for the facility to secure any and all necessary emergency medical care for my child.**



(Signature of parent or legal guardian)

List any special problems your child may have, such as allergies, existing illnesses, previous serious illnesses, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's need to be aware of:

<b>Allergy(s):</b>	<b>Treatment for allergy:</b>
<b>Severity of allergy:</b>	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE

**SCHOOL AGE CHILDREN:**

My child attends the following school:

<b>SCHOOL ADDRESS:</b>	<b>SCHOOL PHONE NUMBER:</b>
<input type="checkbox"/> His/Her immunization record is on file at the school and all required immunization and/or tuberculosis test are current. Vision and hearing screening records are also on file	My child has permission to: <input type="checkbox"/> ride a bus <input type="checkbox"/> be released to the care of his/her sibling(s) under 18 yrs old. <input type="checkbox"/> walk to and from school
Name of sibling(s) under 18 authorized for pick up:	

**IMMUNIZATION RECORD:**

I have provided the childcare operation with a copy of my child's most current immunization record

**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 with-in one week of admission.

Please check only one option:

1.  **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

\_\_\_\_\_  
(Health-care professional's signature)

\_\_\_\_\_  
Date

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

3.  Medical diagnosis and treatment conflict with the tenets and practices of a religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4.  My child has been examined in 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 professionals signed statement and will submit it to the child-care operation.

Name and address of health care professional:



\_\_\_\_\_  
Signature of Parent or Legal guardian

\_\_\_\_\_  
Date

