



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 Teddy's Ladder/Sienna Kids Academy | | Director's Name Schantazia Schannon | |
| 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 | Date of Withdrawal |
| Name of Parent or Guardian Completing Form | | Address of Parent or Guardian (if different from the child's) | |
| List telephone numbers below where parents/guardian may be reached while child is in care. | | | |
| Parent 1 Telephone No. | Parent 2 Telephone No. | Guardian's Telephone No. | Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No |
| Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached | | | Relationship |
| 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 telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID. | | | |
| Name | | Phone Number | |
| Name | | Phone Number | |
| Name | | Phone Number | |

Consent Information

Check All That Apply:

1. Transportation

I give consent for my child to be transported and supervised by the operation's employees:

for emergency care on field trips to and from home to and from school

2. Field Trips

I give consent for my child to participate in field trips.

I do not give consent for my child to participate in field trips.

Comments

3. Water Activities

I give consent for my child to participate in the following water activities:

- water table play
 sprinkler play
 splashing/wading pools
 swimming pools
 aquatic playgrounds

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

- | | |
|--|---|
| <input type="checkbox"/> Discipline and guidance | <input type="checkbox"/> Procedures for release of children |
| <input type="checkbox"/> Suspension and expulsion | <input type="checkbox"/> Illness and exclusion criteria |
| <input type="checkbox"/> Emergency plans | <input type="checkbox"/> Procedures for dispensing medications |
| <input type="checkbox"/> Procedures for conducting health checks | <input type="checkbox"/> Immunization requirements for children |
| <input type="checkbox"/> Safe sleep | <input type="checkbox"/> Meals and food service practices |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director | <input type="checkbox"/> Procedures to visit the center without securing prior approval |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website |

5. Meals

I understand that the following meals will be served to my child while in care:

- 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 | | |

Authorization For Emergency Medical Attention

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

| | | |
|--|---|------------------------------|
| Name of Physician Doctor on Call | Address 8200 Highway 6, Missouri City TX 77459 | Phone Number 713.441.3724 |
| Name of Emergency Care Facility Emergency Care Center | Address 8200 Highway 6, Missouri City TX 77459 | Phone Number 713.441.3724 |

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of.

Does your child have diagnosed food allergies? Yes No Plan Submitted on _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. 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

School Age Children

| | |
|---------------------------------------|---------------------|
| My child attends the following school | School Phone Number |
|---------------------------------------|---------------------|

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/her sibling under 18 years old

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

- Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

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.

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 or she is able to take part in the day care program.

Signature — Health Care Professional

Date Signed

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 recognized 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 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

Address of Health Care Professional

Signature — Parent or Legal Guardian

Date Signed

Requirements for Exclusion

- 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

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) | |
| | 6 months (third dose) | |
| | 15-18 months (fourth dose) | |
| | 4-6 years (fifth dose) | |
| Haemophilus Influenza Type B | 2 months (first dose) | |
| | 4 months (second dose) | |
| | 6 months (third dose) | |
| | 12-15 months (fourth dose) | |
| Pneumococcal | 2 months (first dose) | |
| | 4 months (second dose) | |
| | 6 months (third dose) | |

| Vaccine | Vaccine Schedule | Dates Child Received Vaccine |
|-------------------------|--|------------------------------|
| | 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. | |

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature

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: _____

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



Health Care Professional Statement

Child's Name: _____ DOB: _____

Doctor's Name & Address: _____

The above child is to be cared for by Sienna Kids Academy. State regulations require that each child have up to date immunization records, as well as yearly health checkups.

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)



TEDDY'S LADDER

CONTACT INFORMATION

(Please provide a copy of Driver's License for each parent)

Student Name _____

Mother's Name: _____

Father's Name: _____

Address: _____

Address: _____

E-Mail: _____

E-Mail: _____

Phone #: _____

Phone #: _____

Company: _____

Company: _____

Work Phone #: _____

Work Phone #: _____

Alternate Phone #: _____

Alternate Phone #: _____

The following people are permitted to pick up my child from day care (for the child's protection anyone picking up the child should bring photo ID):

Name: _____

Name: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Alternate Phone #: _____

Alternate Phone #: _____

Drivers License #: _____

Drivers License #: _____

If parent cannot be reached in an emergency situation, the following people should be contacted:

Name: _____

Name: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Alternate Phone #: _____

Alternate Phone #: _____

Parent's Signature: _____

Parent's Signature: _____



TEDDY'S LADDER

Individual Information

Child's Name: _____ Date of Birth: _____

Age: _____ Start Date: _____

What Days & Times will student be attending: _____

Mother's Name: _____ Daytime Phone Number: _____

Father's Name: _____ Daytime Phone Number: _____

Home Phone: _____

Names and ages of other children in the family:

Does your child have any allergies, food restrictions or medical problems?

What are some of your child's favorite foods?

Is your child toilet trained? _____ Is your child fully independent in the restroom? _____

Does your child nap? _____ For how long? _____ Do you prefer we attempt to wake your child by a certain time? _____

What are your child's favorite activities? _____

Are there any areas of difficulty that you would like your child to work on? _____

If yes please explain:

**Please use the back of this form to list any additional information you feel would be helpful in caring for your child.

VIDEO
MINOR RELEASE

I, the undersigned, hereby enter into this Agreement with Teddy's Ladder (Videographer). I have been informed and understand that Videographer is producing a videotape program and that my name, likeness, image, voice, appearance and/or performance are being recorded and made a part of that video recording (the "Video").

1. I hereby grant Videographer the irrevocable right to use my name (or any fictitious name), likeness, image, voice, appearance, and performance as embodied in the Video whether recorded on or transferred to videotape, film, slides, photographs, audio tapes, DVDs or other media now known or later developed. This grant includes without limitation the right to edit, digitally enhance or alter, mix or duplicate and to use or re-use the Video in whole or part, as Videographer may elect. I hereby waive any right to inspect or approve the finished product, including written copy or any other products that may be created in connection therewith. Videographer shall have complete ownership of the Video in which I appear, including copyright interests.
2. I grant Videographer the right to broadcast, exhibit, market, sell and distribute the Video, either in whole or in parts, for any purposes that Videographer, in its sole discretion, may determine, including without limitation advertising and promotion.
3. I confirm that I have the right to enter into this Agreement and hereby give all clearances, copyright and otherwise, for use of my name, likeness, image, voice, appearance, and performance embodied in the Video. I expressly release and indemnify Videographer and its successors, assigns and/or licensees from any and all claims including, without limitation, any and all claims for invasion of privacy, infringement of my right of publicity, defamation (including libel and slander) and any other personal and/or other property rights, arising out of or in any way connected with the above granted uses and representations. I agree that I shall not now or in the future assert or maintain any such claim against Videographer, its successors, assigns and/or licensees.

AGREED AND ACCEPTED:

Child's Name _____

Name: _____

Signature: _____

Date: _____

If in case of a minor:

Parent signature: _____

I agree to the above conditions. I agree that I am the legal guardian of the above-named person and have the legal write to enter into this agreement.



Policies & Procedures Parent Agreement

I have read and completely understand the policies, which include:

- * Curriculum
- * Hours of Operation & Holidays
- * Fee Policy/Late fees/Delinquent accounts
- * Tuition
- * Vacation
- * Procedures for Drop Off & Pick Up
- * Immunizations
- * Health
- * Medications
- * Accidents & Emergency Medical Treatment
- * Discipline
- * Code of Conduct
- * Child Release
- * Parent Involvement
- * Custody & Visitation Issues
- * Withdrawal notice
- * Transportation
- * Meals & Snacks
- * Allergies
- * Fire Drills
- * Toys
- * Hygiene
- * Uniforms
- * Diapers & Toilet Training
- * Naps
- * Birthdays
- * Holiday Celebrations
- * Policy Changes
- * Minimum State Standards
- * Special Needs
- * Vision & Hearing
- * Water Play

I acknowledge that I have read, understand and received a copy of the written operation policies for Sienna Kids Academy.

Please sign the form and return on or before the first day of your child's attendance.

Child's Name

Parent Signature & Date



Communication Form

SKA has several methods of communication that we use to inform our parents of what's happening at the school.

We post signs inside the school, on the doors and hallway bulletin board. We also use text and email messaging.

Please provide us with your email address and a phone number for texting so that we can keep you informed. Please print clearly.

Email: _____

Number for Texting: _____



TEDDY'S LADDER

A Prep School for Elementary

Mosquito/Sunscreen Permission Slip 2021/2022

I give Teddy's Ladder permission to apply bug spray to my child
_____ before outside time.

Please use the following

Off! (Provided by the school)

Other (Provided by parent) _____

(Name of the repellent)

I give Teddy's Ladder permission to apply sunscreen to my child
_____ in the afternoon before outside time.

Parent Signature

Physician's Request for
Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Date: _____

School Year: _____

Part I (To be completed by Parent/Guardian)

Name of Students (Last): _____ (First): _____ Date of Birth: ___/___/___

School Attended: _____ Grade: _____ Student ID#: _____

Which meals will the child eat at school (please circle)? Breakfast Lunch After School Snack

School Nurse/ Nurse Consultant: _____ Contact Information: _____

Parent/Guardian: _____ Phone Number: _____ Email: _____

I give Health Services/ Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent/Guardian Signature

Date

Part II (To be completed by School Nurse or Physician)

Does the child have a disability? Yes No

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.

If yes, please describe the major life activities affected by the disability: _____

Does the child have a life-threatening food allergy? Yes No

If yes to any of the above questions, Part III must be completed and signed by a Licensed Physician.

If no to both questions, Part III may be completed and signed by a Licensed Physician or Recognized Medical Authority.

Part III (To be completed by Licensed Physician or Recognized Medical Authority [i.e. Physician Assistant or Advanced Practice Nurse])

Medical Diagnosis: _____

Foods to be omitted:

Fluid Milk All dairy products All milk protein (casein, whey, etc.) Soy protein
Wheat Gluten Eggs All egg protein (albumin, etc.)
Seafood Corn (as major ingredient) All corn additives (dextrin, caramel color, etc.)
Peanuts All Nuts All foods produced in a facility with nut containing products
Other (please be specific): _____

Foods to be substituted: _____

(For non-disabled students who cannot have fluid milk, food services will choose the most appropriate milk substitute.)

Texture Modification: soft minced pureed other (specify) _____

HISD Formulary - Please choose from the following list:

Boost Kid Essentials 1.0 Nutren Jr. Nutren Jr. with Fiber Peptamen Jr. 1.5 Peptamen 1.5 Nutren 1.5

*Supplements not on the formulary list will take up to 6 weeks to be processed Other: _____

Supplement dosage per meal:

Breakfast Lunch After School Snack Program (if offered)

Will the student eat a regular meal along with receiving a supplement? Yes No

Name of Medical Authority (please print): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Mailing Address: _____

Send completed forms to school nurse/nurse consultant. Physician requests must be renewed each school year. Any change of treatment must be requested in writing by the physician. To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school.

*In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability (Not all prohibited bases apply to all programs) To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.



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

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: 0.15 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

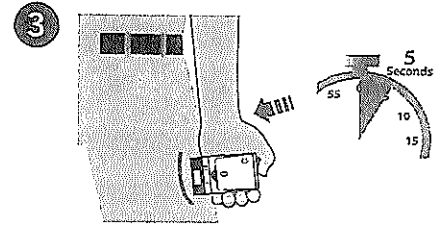
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



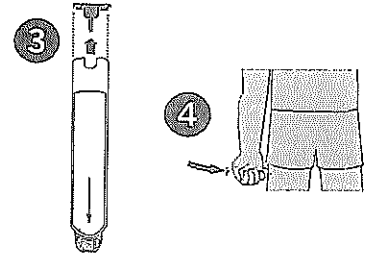
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



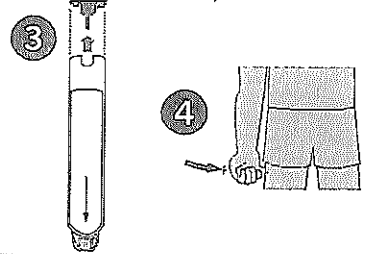
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



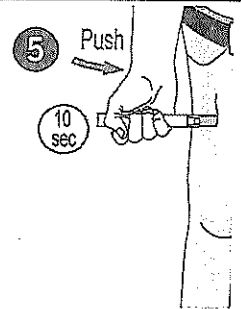
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



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: _____

RELEASE AND WAIVER OF LIABILITY

This is a RELEASE AND WAIVER OF LIABILITY (hereinafter, referred to as the "Release") made this ___ day of, 20___, by and between BLUE TEDDY, LLC, d/b/a/ SIENNA KIDS ACADEMY ("SIENNA") and _____ (Parent(s)/Legal Guardians) who are the Parent(s) and/or Legal Guardian(s) of _____.

WHEREAS, SIENNA provides child care services and the Parent(s)/Legal Guardian(s) have engaged Sienna to provide child care services for _____ (child's name);

WHEREAS, _____ has been requested by the Parent(s)/Legal Guardian(s) to administer emergency treatment (including the administration of epinephrine) to the child during certain emergency situations when the child has come in contact with an allergen and is in danger of anaphylaxis, as prescribed in writing on the child's "Authorization for Emergency Care of Children with Severe Allergies Form" all in accordance with and subject to SIENNA's policy for administering emergency treatment to children with severe allergies.

NOW THEREFORE, in consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Legal Guardian(s) hereby release and forever discharge Sienna and its employees or agents from any liability arising in law or equity as a result of Sienna's employees or agents administering epinephrine and providing other emergency care in conformance with the child's "Authorization for Emergency Care of Children with Severe Allergies Form" (hereinafter referred to as the "Authorization"), provided that Sienna has used reasonable care in administering epinephrine and in providing other authorized care in accordance with the Authorization. This Release shall be governed by the laws of the State of Texas which is the location of the SIENNA facility in which the child is enrolled, excluding its choice of law provisions.

2. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization (including any additional health care provider's instructions or clarifications), that is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matters discussed herein.

3. The reference in this Release to the term SIENNA shall include SIENNA, its affiliates, successors, directors, officers, employees, and representatives. The terms Parent(s)/Legal Guardian(s) shall include the dependents, heirs, executors, administrators, assigns, and successors or each.

4. If one or more of the provisions of this Release shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal, or unenforceable provisions had not been contained herein.

BLUE TEDDY, LLC, d/b/a/ SIENNA
KIDS ACADEMY

Address: _____

By: _____

Name: _____

Title: _____

PARENT(S)/LEGAL GUARDIAN(S):

Name: (print) _____

Signature: _____

Relationship: _____

Date: _____

Name: (print) _____

Signature: _____

Relationship: _____

Date: _____