TEXAS
Health and Human Services

Form 2935
January 2019-E

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 ◯ Both parents ◯ Mom ◯ Dad ◯ 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 ◯ Yes ◯ 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:

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ 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	Address	Phone Number
Doctor on Call	8200 Highway 6, Missouri City TX 77459	713.441.3724
Name of Emergency Care Facility	**Address**	**Phone Number**
Emergency Care Center	8200 Highway 6, Missouri City TX 77459	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				◯ Pass ◯ Fail
Left				◯ Pass ◯ 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/PHOTO
MINOR RELEASE

I, the undersigned, hereby enter into this Agreement with Sienna Kids Academy (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:

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 right 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

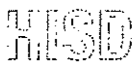
SKA has several methods of communication that we use to inform our parents of what's happening at the school.

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: _________________________________



Nutrition Services
IMPROVING LIVES. BUILDING TRUST.

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."

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ____________________ D.O.B.: ____________

Allergy to: ____________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ____________________

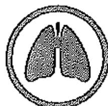
THEREFORE:

☐ 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: ____________

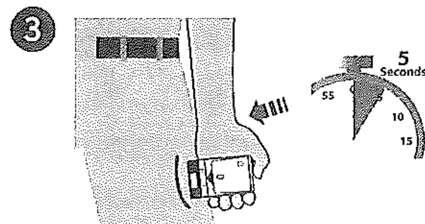
Other (e.g., inhaler-bronchodilator if wheezing): ____________

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

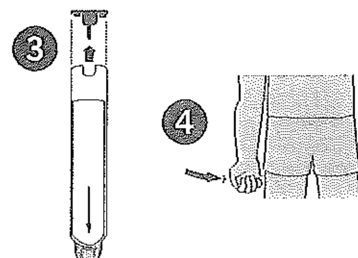
FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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



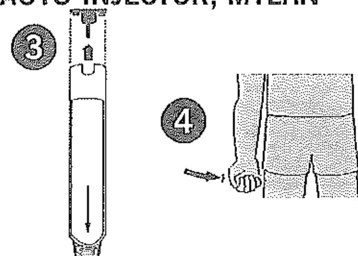
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

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



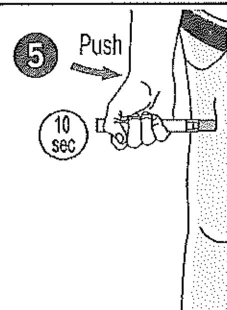
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the 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 p rovisions.

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: _________________________________