



2022-2023 Handbook Acknowledgement

I acknowledge the receipt of the Huntersville United Methodist Church Preschool Handbook and agree to abide by all policies and procedures within. My signature indicates that I understand all financial policies, preschool procedures, and policies related to day to day operations, health and safety, discipline, and the educational program. I understand that failure to follow the policies and procedures could result in my child's dismissal from the program.

Parent Signature(s)

Date

2022-2023 Consent to be Photographed

We will use your child's photograph from time to time within the preschool for special art projects, classroom scrapbooks, slideshows on Preschool Sunday and Graduation etc.

Teachers often send emails to parents that may include a photo of your child's class doing something special. We will not use your child's photo on the preschool website, Facebook page, or any promotional materials without your permission checked below.

_____ By checking here, I give permission for my child's photograph to be used on the preschool website, Facebook page, or in any promotional materials.

_____ By checking here, I **do not** give permission for my child's photograph to be used on the preschool website, Facebook page, or in any promotional materials.

Parent Signature(s)

Date

2022-2023 Family Sharing Authorization

_____ By checking here, I give permission for my contact phone number, and email to be shared with other members of our preschool family for the purpose of room parent activities, arranging play dates and/or birthday celebrations.

_____ By checking here, I **do not** give permission for my contact phone number, and email to be shared with other members of our preschool family for the purpose of room parent activities, arranging play dates and/or birthday celebrations.

Parent Signature(s)

Date



Opening Little Hearts & Minds

2022-2023 Emergency Care Information

Child's Name: _____

Parent/Guardian: _____ Email _____

Cell Phone _____ Work Phone _____ Work Place _____

Parent/Guardian: _____ Email _____

Cell Phone _____ Work Phone _____ Work Place _____

Child's Doctor: _____

Phone: _____

Address: _____

Child's Dentist: _____

Phone: _____

Address: _____

If we cannot contact a parent/guardian, please call:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Parent/Guardian Consent and Agreement for Emergencies:

I consent to have my child _____, receive first aid treatment by HUMC preschool staff in the event of an injury. I understand that HUMC staff will contact 911 in the event of a life-threatening emergency and I hereby authorize HUMC staff to perform any necessary first aid/CPR while waiting for medical assistance to arrive. If it is deemed necessary to transport my child by emergency vehicle to the nearest hospital, I also agree that HUMC staff may authorize emergency medical care by hospital staff in the event that I cannot be contacted immediately.

Parent Signature(s)

Date



2022-2023 Enrollment Questionnaire

Opening Little Hearts & Minds

Child's Name: _____

Child goes by: _____ Birthday: _____

Sibling names, ages, schools: _____

Home Church: _____

What are your child's favorite activities? _____

What are your child's least favorite activities? _____

Is your child fearful of anything (separation, loud noises etc.)?

What things are comforting to your child? _____

What are your expectations for your child at preschool this year?

Any other information that you would like to share: _____

2022-2023 Carpool/Release Information

Child's Name: _____

The following people have permission to pick up my child from preschool (**Please include anyone that may pick up your child from school including those listed on the emergency form**). If the teachers or director do not recognize the person picking up your child, that person will be required to show his/her driver's license and *must* be listed on this form. Thank you for carefully considering who may pick up your child so that we can keep all children safe and secure.

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Parent Signature _____ Date: _____



2022-2023 Physician's Statement

Please note that this form must be signed and stamped by the child's physician. A parent signature is not sufficient.

Child's Name: _____ Date: _____

Date of last "Well Check": _____

Please list any long-term medication(s) taken by this child and possible side effects that we might happen to observe:

Please list any medical, developmental, or behavioral conditions that we should be aware of:

Please list any family/home situations that we should be aware of:

Does child have any allergies to food or medication that we should be aware of?
_____ no _____ yes (*if the answer is yes, please fill out the attached allergy action plan*)

Is the child able to participate in indoor/outdoor physical activities at preschool or preschool summer camp? _____ yes _____ no

Is the child up to date with all immunizations according to the American Medical Association recommendations? _____ yes _____ no

****please attach immunization record***

Physician's Signature _____ Date _____

Address _____

Phone Number _____

Food Allergy Action Plan

Place
Student's
Picture
Here

Name: _____ D.O.B.: ____/____/____

Allergy to: _____

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

Extremely reactive to the following foods: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- ☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)

GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth

SKIN: A few hives around mouth/face, mild itch

GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

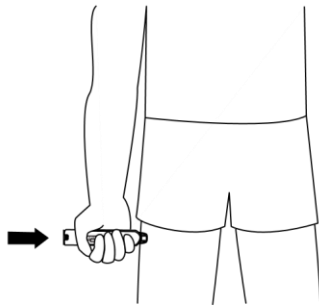
Date _____

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



DEY™ and the Dey logo, EpiPen™, EpiPen 2-Pak™, and EpiPen Jr 2-Pak™ are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions



Remove caps labeled “1” and “2.”

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.



Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.



Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove **GREY** caps labeled “1” and “2.”



Place **RED** rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (____)_____-_____) Doctor: _____

Parent/Guardian: _____

Phone: (____)_____-_____

Phone: (____)_____-_____

Emergency Contacts

Name/Relationship: _____

Name/Relationship: _____

Phone: (____)_____-_____

Phone: (____)_____-_____