Open Arms Learning Center
222 E. Wade St.
Mountain Home, AR 72653
(870) 424-5758

Noah's Ark Preschool
202 Springwood Ave.
Mountain Home, AR 72653
(870) 425-6204

Child's Name:_____ **Birth Date:**_____
Allergies:_____ Medical Conditions:_____
Home Address:_____ Home Phone:_____
City:_____ State:____ Zip Code:_____
Email address:_____ **Enrollment Date:**_____

Days of the Week Scheduled (Circle): M T W TH F Hours:_____
Method of Tuition Payment (Circle): Private - DHS - ABC - Pathways

Father's Name:_____ (Authorized to pick up child) Yes____No____
Cell Phone:_____ Work Phone:_____
Father's Employer:_____ Work Hours:_____ to _____
DL#:_____ Social Security#:_____
Father's Signature:_____ Date:_____

Mother's Name:_____ (Authorized to pick up child) Yes____ No____
Cell Phone:_____ Work Phone:_____
Mother's Employer:_____ Work Hours:_____ to _____
DL#:_____ Social Security#:_____
Mother's Signature:_____ Date:_____

Persons (other than parent/guardian) authorized to pick up the child from the center:
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____
Name:_____ Relationship:_____
Cell Phone:_____ Home Ph#:_____ Work Ph#:_____

Child's Physician:_____ PH#:_____
Address:_____ City:_____ State:____
Insurance Carrier:_____
Please tell us about any beliefs, culture or childbearing practices your child might have:
_____

We are an equally opportunity provider.

Hippa: I, _____ the parent/guardian of _____ give permission for my child's allergy or allergies to be posted in **Open Arms Learning Center** on classroom walls, in the kitchen and other areas as may be needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

Sunscreen: I give written permission for sunscreen to be applied to exposed areas on hot sunny days. I understand that sunscreen will be provided by the center and that if my child has an allergy to any brand of sunscreen, I will provide sunscreen for my child. Permission must be given yearly.

Developmental Screening: Children ages birth through 5 years of age will be screened annually free of charge using the ASQ.

Special needs: I have been informed in writing that all childcare facilities are required by IDEA to refer a child with any suspected delays or disabilities to the appropriate lead agency (as determined by the child's age).

Photography and video permission: I give permission for **Open Arms Learning Center** to photograph/video my child and display photographs/videos throughout the center. I also give permission for my child's photographs/videos to be utilized in an education manner for training purposes and to be submitted to the Baxter Bulletin for special occasions to inform the community about the Open Arms Preschool program and on the Facebook page and/or website.

Photos/Video recordings permission on Social Media/Websites: I give permission for photographs or video recordings of my child to be placed on social media or any other web-sites. This is in accordance with Minimum Licensing Requirements.

YES _____ or NO_____ please check your preference.

Shaken Baby Syndrome: I have been offered the brochure on Carter's Law from Open Arms Learning Center. (www.purplecrying.com)

Discipline: I understand that Open Arms Learning Center has the goal to help children learn acceptable behavior and develop self-control. By signing below you are agreeing the to the discipline policy as stated in the handbook. No physical punishment shall be administered.

Handbook for Families: I have received, read, understand the handbook of **Open Arms Learning Center** and agree to adhere to the said policies and procedures.

Interviews by DHS and Other Agencies: Any staff member or children in attendance may be interviewed by Child Care Licensing, by the Division of Child and Family Services, and/or by law enforcement officers for the purpose of investigations or to determine compliance with licensing requirements. Child interviews do not require parental notice or consent.

Kindergarten Readiness Skills: I have received information of Kindergarten Readiness Skills Calendar for my child (Only for children ages 3 and 4 years old).

Medical Homes: I have received information of medical homes for children for my provider.

Emergency Medical Consent

I, _____ Father – Mother – Guardian (circle one) of _____ (child's name) do hereby give my consent to the Director of **Open Arms Learning Center** or his/her duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed recognized physician or surgeon in case of an emergency when the parents or guardian cannot be reached. I also give consent for the Director or his/her duly appointed representative to transport said child for emergency medical treatment. I have also submitted an updated immunization record for my child.

Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

We are an equally opportunity provider.

Disease History (list the dates of each)

Measles_____ Mumps_____ German Measles_____ Chicken Pox_____

Whooping Cough_____ Contracted Tuberculosis _____yes _____no

Frequent ear infection ____yes ____no Frequent throat infections ____yes ____no

Medications _____Allergies_____

Other conditions or comments:_____

Developmental Needs

Physical or emotional problems the child may have: _____

Child's special food needs:_____

Special Information

Temper tantrums___ Diabetes___ Frequent colds___ Biting___ Sun Sensitivity___ Seizures___

Fainting spells___ Bed wetting___ Other_____

Requires help with:Dressing__ Undressing__ Toileting__ Eating__ Hand washing__

Is the child toilet trained? ___yes ___no Toileting words used _____

Favorite games_____ Favorite toys_____

Siblings ___yes ___no Names & Ages_____

Type of childcare used before_____

Special Customs or Beliefs _____

Other useful information about your child_____

Does your child have health insurance _____ yes _____ no

If yes, who is your health insurance carrier_____

We are an equally opportunity provider.

Behavior Guidance Discipline Policy

Our goal is to help children learn acceptable behavior and develop self-control. Our program is designed to promote positive and enjoyable learning experiences and to build trusting, respectful relationships. A well-planned schedule, classroom arrangement, and curriculum, along with well-trained staff, significantly reduces instances of inappropriate behavior. However, when children do make mistakes in behavior, we use the following guidance techniques.

- Tell the child what he/she CAN do
- Give choices whenever possible, but only when the child really has a choice
- Support children in learning to solve their own problems and work out conflicts
- Re-direct a child to another activity
- Help the children learn how to play with friends

Physical punishment and threats are never used by our staff. Teachers will provide schedules and maintain curriculum to reinforce positive behavior.

Limits of Behavior

Respect others.
Repect yourself.
Respect toys and equipment.

Guidance Policy

At enrollment, parents will be given a written copy of our behavior guidance policy. Parents will also sign an acknowledgement that they have been informed of the policy.

Pattern of Inappropriate Behavior

When a pattern of inappropriate behavior emerges, parents are required to meet with our staff. The goal will be to work together to find a solution to the problem behavior and resolve the difficulty. If outside professional consultation or evaluation is necessary, the center director will invite an appropriate consultant to join the parent-staff partnership.

In cases of biting, if the child bites three times or attempts to bite three times, the parent will be called and the child will be removed from the center for the remainder of that day. If biting continues to be an issue the situation will be reviewed. If all attempts to change that behavior are unsuccessful, we will refer to number 3 on the child dismissal policy.

Child Dismissal

The director reserves the right to dismiss any child.

A child may be dismissed if

1. The parent or child refuses to follow the policies and procedures of the center.
   This may include situations in which repeated requests for updated immunizaion records, emergency contact information, required paperwork, etc. are ignored by parents.
2. Center staff is not able to meet the needs of the child for any reason.
3. The child becomes an endangerment in any way to other children or the staff
   It is not the intent of the director to dismiss any child; every reasonable effort will be made to ensure that dismissal is not necessary.

Please know that No child shall be dismissed from ABC without Division approval for behavior.

Please Sign and Date_____

Dear Parent/Caregiver:

Welcome to our screening and monitoring program. Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. As part of this service, we provide the Ages & Stages Questionnaires, Third Edition (ASQ-3), to help you keep track of your child's development. A questionnaire will be provided every 2-, 4-, or 6-month period. You will be asked to answer questions about some things your child can and cannot do. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal-social skills.

If the questionnaire shows that your child is developing without concerns, we will provide some activities designed for use with ASQ-3 to encourage your child's development and will provide the next questionnaire at the appropriate time.

If the questionnaire shows some possible concerns, we will contact you about getting a more involved assessment for your child. Information will only be shared with other agencies with your written consent.

We look forward to your participation in our program!

Sincerely,

Jill Wilson
Director OALC

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

◯ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

◯ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____
Parent's or guardian's signature

_____
Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____

ASQ-3

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: Child's Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, Parent/Guardian _____ hereby authorize
(Client or Personal Representative)

Open Arms Learning Center, INC. or Noah's Ark Preschool to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to:

Open Arms Learning Center	Noah's Ark Preschool
222 E Wade Ave. J	202 Springwood Ave
Mountain Home, AR 72653	Mountain Home, AR 72653
(870) 424-5758	(870) 425-6204

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): IMMUNIZATION REQUIREMENTS

Specific information to be disclosed: _____
ing my health care

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to you.

I understand that this authorization will expire on the following date, event or condition: January

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

(Signature of Client)	*(Date)*	*(Witness-If Required)*
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

CHILD CARE FOOD PROGRAM

ENROLLMENT FORM

(to be completed by parent or guardian)

Provider's Initial: _____

Date: _____

For Facility/Provider Use Only:

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

Open Arms Learning Center, INC. — Name of Day Care Facility

222 E Wade Ave — Address

(870) 424-5758 — Telephone

Mountain Home, AR 72653 — Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child(ren) will be served the following meals:

(Please Circle): **Breakfast** **AM Snack** **Lunch** **PM Snack** **Supper** **Late Snack**

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days /Week	Gender
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F

Note here any food allergies or special dietary needs your child(ren) have: _____

_____

Doctor's Name: _____ Doctor's Telephone: _____

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____

(form valid one (1) year from this date)

CACFP MEAL INCOME ELIGIBILITY FORM / CHILD CARE

FACILITY NAME: Open Arms Learning Center

PART 1 – *NAME OF ENROLLED CHILDREN*

*OPTIONAL- Participant's ethnic and racial identities *

	Child's Name	Age	Date of Birth	Foster Child	Hispanic or Latino Yes / No	American Indian or Alaskan Native	Asian	Native Hawaiian or Other Pacific Islander	White	Black or African American
1					☐ ☐					
2					☐ ☐					
3					☐ ☐					
4					☐ ☐					

ADDITIONAL HOUSEHOLD CHILDREN: _____ **TOTAL NUMBER IN HOUSEHOLD: _____**

PART 2 – *BENEFITS*: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives benefits, skip to PART 3.**

Name	Case Number
1. _____	_____
2. _____	_____
3. _____	_____

NOTE: Case number is not the number found on the EBT card or an individual's Social Security number

PART 3 – *Check appropriate box*: ☐ **Homeless** ☐ **Migrant** ☐ **Runaway**

If a child you are applying for is homeless, a migrant, or a runaway, please contact your local school, Homeless Liaison, or Migrant Coordinator.

PART 4 – *TOTAL HOUSEHOLD GROSS INCOME:* Please identify your income

*Weekly / Every 2 Weeks / Twice A Month / Monthly / Annual *

Name of all household members, except children listed above	Gross Income (before deductions)	Welfare, Child Support, or Alimony	Pension, SSI, VA Benefits, Social Security retirement	Additional Income	No Income
1. (Example) John Doe	$ 500.00/weekly	$ ____/___	$ ____/___	$ ____/___	___
2. _____	$ ____/___	$ ____/___	$ ____/___	$ ____/___	___
3. _____	$ ____/___	$ ____/___	$ ____/___	$ ____/___	___
4. _____	$ ____/___	$ ____/___	$ ____/___	$ ____/___	___

PART 5 – *Signatures and last four digits of Social Security Number are required*

If Part 3 is completed, the adult signing the form must also provide the last four digits of his/her Social Security Number or mark the "I do not have a Social Security Number" box. (See Statement on the back of this page.)

I certify that all the information provided on this form is true and I understand the following:

- The center or day care home will receive Federal funds based on the information I submit.
- I understand that CACFP officials may verify the information I have submitted.
- I understand that if I purposely submit false information, the participant receiving meals may lose the meal benefit, and I may be prosecuted.

Please acknowledge you have read and understood the statement above by signing the next page.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Valid 1 year from this Date: _____

Signature: _____ Print Name: _____

Address: _____ Telephone #: _____

City: _____ State and Zip Code: _____

Last four digits of Social Security Number: XXX-XX- _____ REQUIRED ☐ I do not have a Social Security Number

This Section is to be completed by Child Care Institution – *DETERMINATION OF ELIGIBILITY*

Household Size: _____

Total Income: $_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: ☐ Free ☐ Reduced ☐ Denied ☐ Tier I ☐ Tier II

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Annual Income Conversion:

- Weekly X 52
- Every 2 Weeks X 26
- Twice A Month X 24
- Monthly X 12

Refer to the current USDA Income Eligibility Guidelines for making determinations of Free, Reduced, or Paid

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating based on race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

For Use During CACFP Review:

HNU Representative Signature: _____

Date: _____

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222 E. Wade Ave.
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Tuition Chart
Effective January 2021

Hours of Operation
Open Arms
&
Noah's Ark
7:00am – 5:30pm

A one time $50.00 registration fee is due upon enrollment

INFANTS/TODDLERS (6 weeks – 3years)
$32.00/Day - $160/week
Half-Day Rate
$20.00 - 4 Hours or less
*(excluding lunch)

PRE-SCHOOL (3years – 5years)
$26.00/day-$130/week
Half-Day Rate
$20.00 - 4 Hours or less
*(excluding lunch)

Before school only (7:00-8:00a.m.) $5.00/day - $25.00/week
After school only (3:00-5:30p.m.) $10.00/day - $50.00/week

SCHOOL-AGE (K-6th) (full time)
$30.00/day-$150.00/week
Half-Day Rate
$20.00 - 4 Hours or less
*(excluding lunch and field trip)

SCHOOL-AGE (K-6th)
After school only(3:00-5:00p.m.) $10.00/day - $50.00/week

DROP-IN (based on availability) Must call in advance of 24 hours at minimum to check for spots available.
Any Age $50.00/day

*** Tuition is due each Friday for the next week of service. **Policy is to pay whether your child is here or not.** A late fee of $25.00 will be assessed to your account if tuition is paid any later than Monday by 10:00 am or if you pick up your child any later than 5:30 p.m. (an additional $10.00 for every 10 minutes after that).
***The following 10 days will be paid holidays. No childcare service will be provided: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Eve, Christmas Day & New Year's Eve.
***Hours of operation may be shortened due to inclement weather. You will not be charged if the center is unable to open.
*** Any day which your child either attends over 4 hours or eats lunch will be considered a full day, which is less than 10 hours of care total per day.
***Although hours of operation are 7:00 am to 5:30 pm, due to ratios we only have limited space available for the early and late hour. Please see the office if you need to pick up after 5:00.
***Rates will be increase periodically to keep up with the cost of living.

Parent/Provider Contract

Child's Name:_____ Enrollment Date: 1/1/2021

Days: M T W R F Hours:_____-_____ Total time___ Weekly Tuition:_____

By signing this agreement, you are accepting all terms. _____
Parent Signature

(Revised Dec 2020 – JW)

Parent Questionnaire
Help us to know about your child!

1. child's FULL name: _____ DOB _____
2. parent's or guardian's names and numbers:
mom: _____ phone: _____ lives with: yes O no O
mom work: _____ phone: _____
dad: _____ phone: _____ lives with yes O no O
dad work: _____ phone: _____
siblings names and ages:

_____

any allergies: yes O no O if yes what are they _____
special medical conditions: _____
any languages besides English spoken at home:
yes O no O if yes what language: _____
What are two goals you have for your child for this school year?
1. _____
2. _____

Tell us about your child!
favorite toy: _____ favorite food: _____
pet/pets: _____ favorite color: _____
favorite outdoor activity: _____ favorite family activity: _____
favorite book: _____
any special assistance they may need:

_____

What would you like us to know? (describe your child)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

parent/guardian signature: _____ date: _____

Thank you for taking the time to tell us about your child and welcome to Open Arms Learning Center!

_____

CCDF Authorized Sign-In Representative Form

For use during COVID-19

Division of Child Care a
Early Childhood Educati

PARENT/GUARDIAN ONLY:

I, _____(parent/guardian name), authorize Jill Wilson/_____(director/teacher name) at Open Arms Learning Center (facility name) to act as an authorized representative on my behalf to sign my child(ren) listed below in and out of the facility during the COVID 19 pandemic to limit the potential spread. List all authorized children below (add additional page if necessary):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I declare under the penalty of perjury that the above information is true and that these children were provided services at the above location and on the days and times authorized. I understand that I must repay any overpayment resulting from false or incorrect information and that I may be prosecuted for fraud.

_____
Print Name

_____ _____
Parent Signature Date

FACILITY ONLY:

I, Jill Wilson (director/teacher) at Open Arms Learning Center (facility name/number), declare under penalty of perjury that the above information is true and that these children were provided services at the above location and on the days and times authorized. I understand that I must repay any overpayment resulting from false or incorrect information and that I may be prosecuted for fraud. The original of this authorization must be kept present with attendance records for each child receiving services during the COVID 19 pandemic.

Jill Wilson
Print Name

Jill Wilson 1/1/2021
Director/Teacher Signature Date

PARENT AGREEMENT

For the Use of Non-standard Playground Items/Activities

My child care provider Open Arms Learning Center has discussed the "plan-of-use" that is attached to this agreement. This plan covers the intended use of playground items/activities that are not commercially manufactured and therefore have not been certified as safe for playground activities and have no manufacturer's installation instructions or recommended use guidelines. Because of this, these items/activities involve some degree of added risk. The plan for each activity has been discussed with me and I understand the risks involved. The Child Care Licensing Unit has reviewed the equipment/activities outlined in this plan and has approved the plan based on the providers agreement that the plan will be implemented and supervised as specified in the plan. The Child Care Licensing Unit will monitor these items/activities to ensure on-going compliance with all of the terms and conditions of the plan.

The use of all items/activities covered by this plan has been explained to me and I have received a copy of the approved plan. Based on this information, I am in agreement that any possible risk to my child is acceptable to me.

I agree to allow my child _____ to participate in the listed activities.

_____ _____

Parent Signature Date

Example:
Pallet Mud Kitchen