



## Trinity Lutheran Ministries

www.tlmjackson.com

Trinity Lutheran Church  
122 W. Wesley St. · Jackson, MI 49201  
517.784.3135

Trinity Lutheran School & Early Childhood Center  
4900 McCain Rd. · Jackson, MI 49201  
517.750.2105

### TRINITY LUTHERAN EARLY CHILDHOOD CENTER

### REGISTRATION FORM

2022-2023

Date: \_\_\_\_\_ New Family: \_\_\_\_\_ Returning Family: \_\_\_\_\_ Start Date: \_\_\_\_\_

Circle Desired Schedule: M T W Th F Drop off: \_\_\_\_\_ Pick-Up: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_

Parents' or Guardians' Name \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Church Home \_\_\_\_\_ Baptized/Dedication \_\_\_\_\_

***Full registration fee of \$50 per student or \$100 per family must accompany registration. The registration fee is non-refundable unless a family moves farther than 50 miles from TLS/ECC prior to the first day of school.***

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(for office use only)

Check # \_\_\_\_\_ Amount: \_\_\_\_\_ Date: \_\_\_\_\_



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**TRINITY LUTHERAN EARLY CHILDHOOD CENTER  
CONTRACT  
2022-2023**

This contract is made between the parent(s)/guardian(s):

Name of Parent(s)/Guardian(s):

\_\_\_\_\_

Address of Parent(s)/Guardian(s):

\_\_\_\_\_

E-mail: \_\_\_\_\_ Primary phone #: \_\_\_\_\_

and Trinity Lutheran Early Childhood Center for the care of the following children:

(circle one)

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male or Female

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male or Female

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male or Female

**SCHOOL PROGRAMS:**

Circle program(s):    Preschool 3                      Prekindergarten 4

Circle Option:            Half Day OR Full Day    Half Day OR Full Day

Circle 2, 3, or 5 days:   M T W Th F                      M T W Th F

**Tuition payment is monthly.** The payment shall be \$\_\_\_\_\_ per month and is due in advance on the 20<sup>th</sup> for the following month (Ex. August 20<sup>th</sup> is the payment date for September tuition).

**CHILD CARE PROGRAMS:**

Circle program(s):    Infants    Toddler 1    Toddler 2    Extended Care (Before/After School)

**Tuition payment is weekly.** The payment for care shall be \$\_\_\_\_\_ per week, is due in advance for the following week, and reflects a schedule as follows:

Arrival time: \_\_\_\_\_ am/pm                      AND                      Pick up time: \_\_\_\_\_ am/pm

Arrival time: \_\_\_\_\_ am/pm                      AND                      Pick up time: \_\_\_\_\_ am/pm

On the following days (circle all that apply):    M T W Th F

**Registration Fee:** \$50.00 per child; \$100.00 per family; nonrefundable.

This is a onetime fee as long as your child(ren) are enrolled continuously. The registration fee will be charged again to families who withdraw their child(ren) from the program for the summer or other extended periods of time.

**Tuition Payment Policy:** Tuition is charged for both EC school and child care programs that the child has been enrolled and scheduled to attend. Tuition is due for the days your child has been scheduled in advance regardless of absence due to illness, vacation, or other reasons. A two week notice must be given to cancel scheduled child care. Tuition is on a prepay basis; it must be paid in advance.

- **Monthly Payments:** Tuition is charged monthly for school programs (Preschool 3, Prekindergarten 4) that the child is enrolled. Monthly tuition payment is due on the 20<sup>th</sup>.
- **Weekly Payments:** Tuition is charged weekly for child care programs (infant, toddler, extended care before/after school) that the child is scheduled to attend. Weekly tuition payment is due in advance by Friday for the following week.

#### **Family Discounts:**

**Infant, Toddler, Preschool, Extended Child Care** - A 10% tuition discount will be applied to the tuition rates of the oldest child(ren) for families with two or more children.

**Child Care Network & DHHS Assistance Programs:** Trinity will accept families who are approved for tuition assistance through one of these programs. Parents are responsible for any tuition charges not paid by these programs, including charges for child care provided prior to being authorized for child care tuition assistance and for charges for child care provided after the parent has been disqualified for tuition assistance.

**Late Pick Up Fee:** If a parent is going to be late picking up a child, every effort must be made to contact the provider. A \$1.00 per minute late fee will be charged to parents who pick up their child after 6:00pm. A \$1.00 per minute late fee will be charged to parents who have scheduled their child to attend for a half day (less than 5 hours) and do not pick up their child at the designated time, unless the parent has contacted the office to extend their child's time in advance and this extension was approved. Trinity reserves the right to schedule other children to attend to offset half day and part time attendance schedules. A late pick up can create a staffing problem in terms of State Licensing required adult/child ratios.

**Meals and Snacks:** Trinity will provide a morning and an afternoon snack to children present during those times, except for infants. Parents are responsible for providing meals (breakfast and lunch) for their child(ren). On full school days breakfast and lunch may be purchased for your child through the school food program. These costs are billed separately. Please be sure to make a separate payment when an invoice is received.

**Infant Meals and Snacks:** Parents must provide all formula and food for their baby in our infant program.

**Infant and Toddler Diapering Needs:** Parents must provide diapers, wipes, and diaper ointment for their infant or toddler.

**Tuition on No School Days (No school for half day, full day or snow day)** – Children enrolled in an EC school or an elementary school program will not have school on certain days per the school calendar. If child care is needed, parents must schedule the child care in advance for these days for an additional tuition charge (see tuition rate schedule); a form will be provided to parents to schedule this child care. Child care fees will not be charged on these days for children who are not scheduled to attend.

**Holidays and Vacation:** The provider will not be open for child care on the following holidays; child care tuition will not be charged for these days.

New Year's Eve Day	New Year's Day
Memorial Day	Good Friday
July 4th (Independence Day)	Labor Day
Thanksgiving Day	Friday After Thanksgiving
Christmas Eve Day	Christmas Day

**Holidays and Vacations To Be Determined & Announced:** The provider may be open for child care, depending on scheduled attendance, on the following vacation break periods.

**Snow Days:** The center will make every attempt to be open on the days schools are cancelled. In the event that the center is closed, there will be no child care charges for the day. You can receive Automatic Text Messages announcing snow days and other events. Ask in the early childhood office or school office about how to sign up for this service.

**Withdrawal from Program:** A two-week notice is necessary for cancellation of an EC school program or child care services. If a two-week written notice is not given, two weeks additional tuition will be billed at the time of withdrawal. All fees must be paid at the time care is ended. The Center may request withdrawal of a child for issues stated in this parent contract or parent handbook.

**Summer Enrollment/Fall Renewal:** A new contract will need to be signed for summer child care. If a sufficient number of children are enrolled, a summer child care program will be offered. Those that do not need summer care but want to return the next school year will need to pay a "place" holding fee depending on the age of your child. Family discounts will apply. This fee will be due by the end of the school year.

**Termination Procedures:** This contract may be terminated by the parent(s) or the provider. A two week notice prior to the last date of care is required. The provider may immediately terminate this contract without any notice if payment is not made on time.

**Comprehensive Background Checks:** Trinity Lutheran requires a comprehensive background checks on its employees and unsupervised volunteers.

**Other:** If the provider chooses not to enforce any portion of the contract, it does not give up the provider's right to enforce any other portion of the contract. The contract can be revised at any time by the provider if necessary.

The signature(s) below indicate agreement with this contract and with the written policies of the provider (contained in the Parent Handbook). The provider may change policies as needed with advance written notice.

***Parents/Guardians are responsible for timely payment of the tuition fees. Collection costs may be added, if needed, to obtain payment of all amounts due.***

_____	_____	_____
Parent's Name/Guardian's Name	Parent's Signature/Guardian's Signature	Date
_____	_____	_____
Parent's Name/Guardian's Name	Parent's Signature/Guardian's Signature	Date
_____	_____	_____
Early Childhood Director's Name	Early Childhood Director's Signature	Date



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### Trinity Lutheran Early Childhood Center 2022-2023 Tuition Rates

#### **\*\*New Rates Effective January 17th\*\***

##### **Infant & Toddler Programs-**

- Infants (birth to approx. 16 months)
- Toddler 1 (approx. 16-26 months)
- Toddler 2 (approx. 26-36 months)
- Full Day Child Care Options – 7:00 a.m. to 6:00 p.m.
- Half Day Child Care Options – Five hours or less

Weekly Rates	5 Days	4 Days	3 Days	2 Days
Full Days	\$225.00	\$240.00	\$183.00	\$125.00
Half Days	\$178.00	\$157.00	\$120.00	\$84.00

##### **School Age Program-**

Weekly Rates	4 Days	3 Days	2 Days	1 Day
\$170.00	\$139.00	\$107.00	\$75.00	\$38.00

##### **Program Options for Preschool 3 & Preschool 4**

- Full Day Option - 8:00 a.m. to 3:00 p.m.
- Half Day Option - 8:00 a.m. to 11:30 a.m.
- Choice of five days, four days, three days, or two days.
- Child must be three by December 31<sup>st</sup> for Preschool 3.
- Child must be four by December 31<sup>st</sup> for Prekindergarten 4.

Preschool 3's	Monthly Rates	Monthly Rates
Preschool 4's	January 1 – June 1	January 1 – June 1
Scheduled	Full Day	Half Day
Attendance	8:00 a.m. – 3:00 p.m.	8:00 a.m. – 11:30 a.m.
Five Day Rate	\$405.00	\$202.50
Four Day Rate	\$326.00	\$163.00
Three Day Rate	\$250.00	\$125.00
Two Day Rate	\$170.00	\$85.00

##### **Extended Child Care- Before/After School, No School Days**

- Child Care available for both options from 7:00 a.m. to 8:00 a.m. AND 3:00 p.m. to 6:00 p.m.
- Full Day on no school days
- Child Care may be scheduled for half days, no school days, some holidays, and school vacation periods.
- Rate of \$6.00 per hour rate would apply.

**For more information, please contact the Early Childhood Center**

**Phone: 517-750-2105 or email [office@tlsjackson.com](mailto:office@tlsjackson.com)**

# CHILD INFORMATION RECORD

## State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

<b>For Provider Use Only:</b>		Date of Admission		Date of Discharge	
Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Home Phone (     )	Parent/Legal Guardian's Name (Optional)		Home Phone (     )
Home Address (if not child's address)		Cell Phone (     )	Home Address (if not child's address)		Cell Phone (     )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address		
Employer Name		Work Phone (     )	Employer Name		Work Phone (     )
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number (     )		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)					

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

<b>Emergency Contact &amp; Release of Child:</b> List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)					
1.		(     )	(     )		
2.		(     )	(     )		
3.		(     )	(     )		
<b>Release of Child Only:</b> List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)					
1.		(     )	2.		(     )
3.		(     )	4.		(     )

<b>Parent/Legal Guardian Initials:</b>
_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.
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Signature of Parent or Guardian	Date Signed
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Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

# HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

## PERSONAL

CHILD'S NAME (Last, First, Middle)		DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI / /
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI / /
		WORK TELEPHONE NUMBER ( )

## SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	If yes, list medications:
Reason for Medication _____				
/ /				Was the health history reviewed by a health professional?
Parent/Guardian Signature _____ Date _____				<input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance							Weight			
		Other: _____					<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT				
		Date: / /	Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
		URINALYSIS	Sugar						TUBERCULIN	Type: _____			
			Albumin										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	Level _____ ug/dl				<b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						
		Date: / /											

### Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /



### SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.\*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
Tdap	1		OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Haemophilus Influenzae type b (HIB)	1	3		1	
	2	4		2	
Polio (IPV/OPV)	1	3		3	
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2	4			
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused Immunizations: <input type="checkbox"/>		
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____ Health Professional's Signature			_____ Title		
			_____ Date		

### SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness?
		If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

### SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined \_\_\_\_\_'s teeth. As a result of this examination, my recommendation for treatment is: \_\_\_\_\_

child's name

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date

### PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Examiner's Name (Print or Type)

\_\_\_\_\_  
Degree or License

\_\_\_\_\_  
Number & Street

\_\_\_\_\_  
City

\_\_\_\_\_  
MI

\_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Telephone

Information required for:

**Early On** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** - Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.



# PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

## Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

I have read the above statement issued by Trinity Lutheran Preschool and Child Care Center .

\_\_\_\_\_  
Name of Child Care Center

Child(ren)'s Name(s) \_\_\_\_\_  
\_\_\_\_\_

Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date

LARA is an equal opportunity employer/program.  
Auxiliary aids, services and other reasonable accommodations are available upon  
request to individuals with disabilities.

# Trinity Lutheran School & Child Care

*Academic Excellence ♦ A Safe & Respectful Place ♦ Sharing the Love of God*

## **PARENT PERMISSION FOR TOPICAL NON-PRESCRIPTION MEDICATIONS** **(sun screen, bug spray, diaper ointment)**

Written parent permission is required by Licensing Rules in order for the Early Childhood Center staff to apply any topical medications and products to your child. If you would like to have ECC staff apply the listed topical products, please complete the information requested below, sign, and date the form. You will need to provide the unexpired product in the original container labeled with your child's first and last name. Please be sure to give the first application of any of these solutions at home in order to evaluate your child's reaction to that product. For any other topical solutions, please complete and sign a medication form to give staff permission to apply.

**Child(ren) Names:**

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### **Sun Screen**

\_\_\_\_\_ I give permission to Trinity Lutheran Early Childhood Center staff to apply Sun screen that I supply to my child prior to outside play.

\_\_\_\_\_ I do not give permission for sun screen to be applied to my child. I understand that my child will be outside for a minimum of 30 minutes each day.

### **Bug Spray**

\_\_\_\_\_ I give permission to Trinity Lutheran Early Childhood Center staff to apply bug spray that I supply to my child prior to outside play.

\_\_\_\_\_ I do not give permission for bug spray to be applied to my child. I understand that my child will be outside for a minimum of 30 minutes per day.

### **Diaper Ointment (for infants & toddlers only)**

\_\_\_\_\_ I give permission to Trinity Lutheran Early Childhood Center staff to apply diaper ointment that I supply to my child.

\_\_\_\_\_ I do not give permission for diaper ointment to be applied to my child.

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Parent or Guardian Signature

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Date

# Trinity Lutheran School & Child Care

*Academic Excellence ♦ A Safe & Respectful Place ♦ Sharing the Love of God*

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## PHOTO RELEASE FORM

Trinity staff occasionally takes pictures of children engaged in various activities at the Early Childhood Center. These pictures may be used in the classrooms, the website, any advertising (posters, brochures, etc.), and the Citizen Patriot newspaper. Parental permission to use photos for these purposes is requested. Please complete and select one of the options below, sign and date this form. Thank you.

**Name(s) of Child (Children)**

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\_\_\_\_\_ I give permission for Trinity Lutheran Preschool and Child Care to take photos of my child(ren).

\_\_\_\_\_ I give permission for Trinity Lutheran Preschool and Child Care to take photos of my child(ren) with the following restrictions:

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\_\_\_\_\_ I do not want Trinity Lutheran Preschool and Child Care to take photos of my child.

**Parent or Guardian Printed Name:** \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_