# Hinesville First United Methodist Church Preschool and Kindergarten

## A Safe Place to Grow!

**203 North Main Street, Hinesville, GA. 31313**
**Telephone #: 912-368-3355 Email: info@hinesvillefumcpreschool.com**
**Website: hinesvillefumcpreschool.com**

Welcome to Hinesville FUMC Preschool and Kindergarten. We are so excited that you have chosen our program to educate, minister to, and care for your child. We are honored that you have made FUMC Preschool and Kindergarten your 1st choice to early learning. Attached is your child's enrollment packet. Please look over this checklist to help ensure that you and your child get started properly. All forms must be updated annually and required on file before your **child may start school**.

_____ Physician's Statement

_____ Immunization Record GA Form 3231 (Certificates may be obtained at the Liberty County Health Department, private physician, or for military dependents, Winn Army Community Hospital.)

_____ Media Release Form

_____ Emergency Treatment Form

_____ Student Release Form

_____ Authorization to Dispense External Preparations

_____ Authorization to dispense prescribed medication. (If applicable) Prescribed medication must be in original container with RX number. **Medication and form must be cleared by director before a FUMC staff member can dispense medication.**

_____ Allergy Action Plan with prescribed Epinephrine and/or Antihistamine. (If applicable) **Allergy Action Plan with prescribed Epipen/Antihistamine must be cleared by director before a FUMC staff member can dispense medication.**

_____ Copy of Child's Social Security Card (Kindergarten Only)

_____ Copy of Child's Birth Certificate (Kindergarten Only)

_____ Certificate of Ear, Eye, and Dental Examination GA Form 3300 (Kindergarten Only)

**Due to health and safety regulations, students will not be allowed to start school until all forms are current. FUMC Preschool and Kindergarten reserves the right to change, combine, or cancel classes based on enrollment needs.**

**Enrollment packet may be:**
**Emailed to info@hinesvillefumcpreschool.com**
**Faxed to 368-6179 attn: Marian Letnaunchyn**
**Mailed to FUMC Preschool and Kindergarten**
**203 North Main Street**
**Hinesville Georgia 31313**
**Hand delivered to school office the week of July 25 – July 29 between the hours of 9:00 to 1:00.**

School will be closed for the summer. Summer hours are by appointment only. If you would like to schedule an appointment, please leave a message on the school phone or email info@hinesvillefumcpreschool.com. If you have additional questions, please email or call.

School Office will reopen Monday, July 25, 2016 9:00 – 1:00
Open House: Monday, August 8, 2016 5:00pm – 6:00pm
First day of school: Tuesday, August 9, 2016

Marian Letnaunchyn
Cell # 912-432-0340

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**Physician's Statement**

Child's Name: _____

Date of Exam: _____

I have examined the above child on the above date and see no physical or emotional reason to restrict participation in the activities of the Hinesville First United Methodist Church Preschool & Kindergarten.

I have noted the following, if applicable:

Restrictions of Activity:

Special attention or care needed:

List current health issues/allergies:

_____

_____

List current prescribed medication:

_____

_____

I also certify this child's immunizations are up to date.

Physician's Signature: _____ Date: _____

Physician's Signature Block:

**Please attach a copy of Georgia Form 3231.** (Form 3231 not valid without name, birth date of child, date of expiration or x in complete for school attendance box, legible name and address of the physician or health department certified by signature and date of issue.)

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**Photo Usage**

During the year FUMC Preschool and Kindergarten staff will be taking pictures of activities and events happening at our school. The pictures of our students and staff tell the story of our school! Please let us know by signing below if we can use your child's picture for school purposes.

Child's name _____

| Photo Usage Permission | Parent/Legal Guardian Signature |
|---|---|
| **Yes**, I give permission for my child's picture to be used for school purposes to include, but not limited to school website, and face book page. | |
| **No**, I do not give permission for my child's picture to be used for school purposes to include, but not limited to school website, and face book page. | |

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**Emergency Treatment Form**

Name: _____

Child's Physician: _____ Phone #: _____

Health Insurance Company: _____Policy #:_____

Hospital Emergency Room that my child would normally use (Please circle):

Winn Army Hospital Liberty Regional Medical Center

**Emergency Treatment**

In the event of an illness or accident which requires immediate medical treatment at a time when a parent cannot be located, I give permission to the Director of the Hinesville First United Methodist Preschool & Kindergarten, or other school personnel designated by the Director, to authorize such treatment. I will hold neither Hinesville First United Methodist Preschool & Kindergarten nor medical personnel responsible. This is done with the understanding that every attempt will have been made to contact parents, the child's physician, and other persons listed for emergency contact.

The physician and hospital listed above are hereby authorized to provide any emergency care deemed necessary for my child. In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital if necessary.

In the event of an emergency, I authorize the staff of Hinesville First United Methodist Preschool & Kindergarten to administer any first aid care deemed necessary for my child.

Health issues/Allergies:

_____

_____

Medications: (An authorization for medication form needs to be filled out and kept on file in the office for prescription medication to be administered while child is at school. This form is available at the school office.)

_____

_____

Best number to reach parent/legal guardian in case of an emergency.

Name _____ Telephone number _____

Name _____ Telephone number _____

Signed: _____ Date: _____

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### STUDENT RELEASE FORM

Per our Parent Handbook, we are unable to release your child to anyone other than the parent or guardian, unless we have prior written notification. **Phone calls will not be accepted**. Please write down the name/s of people that are authorized to pick up your child. It is the responsibility of the parent/legal guardian to keep the student release form updated. This is solely for your child's safety.

Student Name_____

Mother Name _____

May the Child be released to Mother? _____ (If No, Legal Documentation Required)

Father Name _____

May the Child be released to Father? _____ (If No, Legal Documentation Required)

| Person authorized to pick up my child | Relationship to child |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**As a parent, I am responsible for communication with the designated person regarding pick up responsibilities and dates. I understand that the school imposes a late pick up fee for each time a child is left at school past 1:00 pm. I understand that any person picking up is required to show ID upon request.**

Parent Signature_____Date_____

Parent home phone_____ Parent cell phone_____

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Authorization to Dispense External Preparations

Our teachers strive to provide a safe environment for your child to play, learn and grow. Part of the teacher's job is to administer first aid. For children not yet potty trained it is the teacher's responsibility to meet the basic needs of keeping your child clean and dry. The following may be applied to your child when a FUMC staff feels it is appropriate or necessary. By checking off the following items, and signing this document you are giving permission for FUMC staff to apply the following. Do not approve anything that your child is allergic to. It is the parent's responsibility to notify the teacher if their child is allergic to any particular name brands or ingredients in the items listed below.

I give FUMC Preschool and Kindergarten Staff permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container. Please check all that can be applied.

_____ Baby Wipes
_____ Band-aids
_____ Neosporin or similar ointment
_____ Bactine or similar first aid spray
_____ Sunscreen
_____ Insect Repellent
_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
_____ Hand sanitizer

Other (please specify) _____

Child's Name _____

_____ _____
Parent/Guardian Signature Date

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**AUTHORIZATION FOR PRESCRIBED MEDICATION ONLY**

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____ Expiration Date: _____

Time Medication is to be given: _____
**(Medication will not be given on an "As Needed" basis, specifics must be provided)**

Amount of Medication to be given: _____

Dates to be given: _____
**(Not to exceed two weeks without a physician's statement)**

_____ _____
PARENT'S SIGNATURE DATE

**FOR School Use (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)**

| | Date | Time Given | Amount | Any adverse reactions | Administered by |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |

If noticeable adverse reaction to medication, what action was taken? Describe:

Date medication returned: _____ Parent Signature _____

Reason for return: _____

Staff member returning medication signature _____

**Attention to Person Requesting Medication Be Dispensed:**
**Please submit form and medicine to director. Form must be completed in its entirety before the school can dispense any medication. Medication must be dispensed in the original container. Prescription number on the container must match prescription number listed on form. Medicine exchange will be between parent and staff member. Medicine will not be handled by children or transported/stored in backpack.**

# Food Allergy Action Plan

Place Child's Picture Here

**Student's Name:**_____ **D.O.B:**_____ **Teacher:**_____

**ALLERGY TO:**_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

**Symptoms:**

**Give Checked Medication**:**
(To be determined by physician authorizing treatment)

| | | |
|---|---|---|
| ▪ If a food allergen has been ingested, but *no symptoms*: | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Mouth — Itching, tingling, or swelling of lips, tongue, mouth | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Skin — Hives, itchy rash, swelling of the face or extremities | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Gut — Nausea, abdominal cramps, vomiting, diarrhea | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Throat† — Tightening of throat, hoarseness, hacking cough | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Lung† — Shortness of breath, repetitive coughing, wheezing | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Heart† — Thready pulse, low blood pressure, fainting, pale, blueness | ☐ Epinephrine | ☐ Antihistamine |
| ▪ Other† _____ | ☐ Epinephrine | ☐ Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give | ☐ Epinephrine | ☐ Antihistamine |

The severity of symptoms can quickly change. †Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give_____
medication/dose/route

**Other:** give_____
medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____ ) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

| Name/Relationship | Phone Number(s) | |
|---|---|---|
| a. _____ | 1.)_____ | 2.) _____ |
| b. _____ | 1.)_____ | 2.) _____ |
| c. _____ | 1.)_____ | 2.) _____ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

**TRAINED STAFF MEMBERS**

1. _____ Room _____

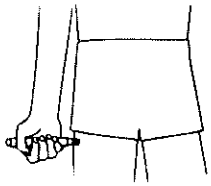
2. _____ Room _____

3. _____ Room _____

## EpiPen® and EpiPen® Jr. Directions

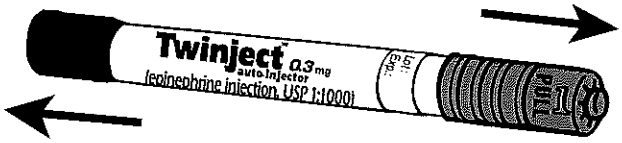
- **Pull off gray activation cap.**


- **Hold black tip near outer thigh (always apply to thigh).**



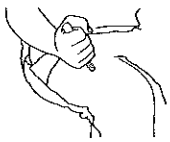
- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

## Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions




- **Pull off green end cap, then red end cap.**

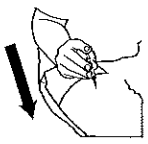
- **Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.**



**<u>SECOND DOSE ADMINISTRATION</u>:**
**If symptoms don't improve after 10 minutes, administer second dose:**

- **Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow or orange collar off plunger.**

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



**Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

**For children with multiple food allergies, consider providing separate Action Plans for different foods.**

The Food Allergy & Anaphylaxis Network

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*