LIBERTY SCHOOL DISTRICT No.25
LEAP PROGRAM
2017-2018

In accordance with the Arizona Department of Health Services the student to teacher ratio is 1 to 20. In an effort to keep track of the LEAP Program ratio **please complete the information below.**

Child's Name	Grade	Teacher's Name

School your child attends:

Estrella Mountain — Freedom — Liberty
Rainbow Valley — Westar — Las Brisas

Which program will your child be attending?

AM only $80/Mo. PM only $210.00/Mo. Both AM & PM $235.00/Mo.

Las Brisas Student AM only $155 Las Brisas Student PM only $130

Early Release Only $60 10 USE Occasional Block $135 – Each session = 1 use

Please Check:	Mon	Tues	Wed	Thurs	Fri
Morning:					
Afternoon:					

$30 Annual Registration fee due per child

I understand:

- ☐ **A written notification must be given to the District Office at least two weeks in advance to change program usage or withdraw from the program.**
- ☐ **Additional fees are required for non school days ie. breaks and inservice days**

X______________________________ ______________________________
Parent / Guardian (PRINTED) E-mail Address:

X______________________________ ______________________________
Parent / Guardian (SIGNATURE) Date:

CDC/SGH# or name:________________

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: ☐ male ☐ female

Mother or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Father or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):______________

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	☐ No	☐ Yes
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	☐ No	☐ Yes
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	☐ No	☐ Yes
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? If yes, list precautions:	☐ No	☐ Yes
Additional comments:		
Other special instructions:		

This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:

COMMITTED TO STUDENT SUCCESS

Liberty Elementary
623-327-2810 Office
623-327-2819 Fax

Estrella Mountain Elementary
623-327-2820 Office
623-327-2829 Fax

Rainbow Valley Elementary
623-327-2830 Office
623-327-2839 Fax

Wester Elementary
623-327-2840 Office
623-327-2849 Fax

Freedom Elementary
623-327-2850 Office
623-327-2859 Fax

Parent/Guardian Media Consent Form

This "Media Consent" form allows Liberty Elementary School District to videotape and photograph your child with his/her teacher this school year. The purpose of the video and/or photographs is to provide a resource of reflection.

WEB/INTERNET PUBLISHING

1. Image - Make one selection only:

A.____ I will allow my child's image (including photograph and video) to be published on the school and/or District website.

B.____ I will *not allow* my child's image to be published on the school and/or District website

2. Schoolwork– Make one selection only:

A.____ I will allow my child's schoolwork (including photograph and video) to be published on the school and/or District website.

B.____ I will *not allow* my child's schoolwork to be published on the school and/or District website

District Publishing (for use by the District)

3. Make one selection only:

A.____ I will allow my child's image (photo, audio and video), to be used by the District for promotional purposes. Photos may be published in the form of print, electronic presentations or video materials created for District use and/or community-wide distribution.

B.____ I will *not allow* my child's image to be used by the District for promotional purposes.

Please read, sign below and return to your child's school. Thank you.

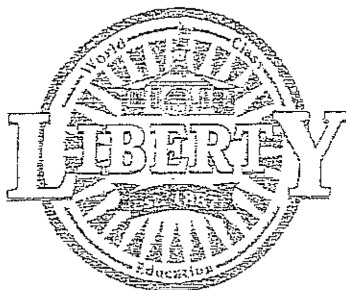
I understand that, in the event the school or district uses photographs and/or video footage of my child, that no compensation will be made to me for this use. I also understand that this form is applicable only for the duration of my child's enrollment at the school mentioned below and that I will be required to complete a new form to make changes or when my child enters a new school. I acknowledge by my signature below that I understand the above stated information.

Student's Name: (please print) ____________________ Student's Grade: ____________

Print name of Parent/Guardian: (print) ____________________ Teacher's Name: ____________

Signature of Parent/Guardian: (sign) ____________________ Date: ____________

Relation to Student ____________________



BUILDING WORLD CLASS SCHOOLS IN YOUR NEIGHBORHOOD

Dr. Andrew L. Rogers, Superintendent

Governing Board
Mr. Mike Greenfield
Mr. Daniel Higgins
Mr. Paul Jensen
Mr. Mike Newman
Dr. Kathy Shelton

On occasion LEAP Extended Day will be showing PG rated movies that are age appropriate. Movies to be shown on the given day will be posted at the sign-in desk along with the movie rating. The below form gives your child permission to view PG rated movies. If you turn in the form below and decide there is a movie you do not want your child to watch, please notify a staff member. We will find an alternative activity for your child to do during this time.

I ____________________________________give permission for my child(ren)

_________________________ Can watch PG movies Cannot watch PG movies
Child's Name

_________________________ Can watch PG movies Cannot watch PG movies
Child's Name

_________________________ Can watch PG movies Cannot watch PG movies
Child's Name

_________________________ Can watch PG movies Cannot watch PG movies
Child's Name

______________________________________ __________________
Parent Signature Date

THE LIBERTY SCHOOL DISTRICT
19871 West Fremont Road • Buckeye, AZ 85326 • Office (623) 474-6600 • Fax (623) 474-6669

Arizona Department of Health Services
Bureau of Child Care Licensing

MEDICATION CONSENT FORM

First & Last Name of CHILD:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			

I give permission for the administration of the medication, according to the instructions listed, to the child listed above.

Date of authorization:	Signature (parent/guardian):

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

____

____

* Injections: Attach health care provider's written authorization.

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FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	☐	☐
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?	☐	☐
Is the full name of the child on the container?	☐	☐
Is the prescription or over-the-counter medication current?	☐	☐
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?	☐	☐
Staff initials:__________		

Please use the second page to document administration of the medication.

Name of Child:

DATE	NAME OF MEDICATION	RX#	DOSE	TIME	FULL SIGNATURE of AUTHORIZED STAFF PERSON

ACKNOWLEDGEMENTS AND VERIFICATIONS

This form must be returned to your LEAP Site within 10 days.

Child's Name (Print) ______________________________

Child's Name (Print) ______________________________

Child's Name (Print) ______________________________

Child's Name (Print) ______________________________

Parent/Guardian's Name (Print)______________________________

By signing below you acknowledge and verify that you have received and taken the responsibility to review the L.E.A.P Parent Handbook. The procedures were designed to create an orderly environment that is safe for all children and the staff. The rules are reasonable and fair and they are the same at all of the L.E.A.P. sites. We ask that you read this handbook carefully.

Please note: Federal privacy laws prohibit L.E.A.P. Staff from naming students involved in disciplinary actions and from revealing the consequences of those actions to the parents of other students.

Signature of Parent/Guardian ______________________________Date ___________

Signature of Child ______________________________Date ___________

Signature of Child ______________________________Date ___________

Signature of Child ______________________________Date ___________

TEXT MESSAGE PERMISSION FORM

LEAP Parents,

Your children and their safety are of the upmost importance to us. It is imperative that we know which days to expect your children, as well as which days they will be absent from the program. Please notify your site leader by phone or email the days your children will be attending or subsequently the days they will be absent. In the event your child does not attend the program, on a scheduled day, we will be sending a text message to notify you as soon as roll call has been completed. If your child should be with us, please contact us immediately so we can help with the process of locating them. Please complete the form below with the most reliable cell phone information. If you prefer a different method of notification, please indicate below.

Parent/caregiver details

Name:
Cell phone number:

Students

Name:
Name:
Name:
Name:

☐ Please contact me via text message in conjunction with my child's/children's attendance.

☐ I Do Not give LEAP Extended Day permission to contact me via text message. Please contact me via____

Date:____

Signature of parent/guardian:____