Admission Date: _____
Withdrawal Date: _____

THE CHILDREN'S SPOT
1222 E. Debbie Lane
Mansfield, Texas 76063
817-473-0441
Owner: Ashley Shuffield
Director: Cheryl Butimore

Hours Enrolled: _____
Days Enrolled: _____

ENROLLMENT FORM

CHILD'S FULL NAME: _____ Date of Birth: _____
Address: _____ City/Zip: _____ Home Phone: _____
Who does your child reside with? _____Mother & Father, _____Mother, _____Father,
_____Mother & Stepfather, _____Father & Stepmother, _____Grandparents, _____Other: Please explain.

_____

PARENT'S / GUARDIAN'S NAMES: _____
Address (if different from children): _____ City/Zip: _____

MOM: CELL #/CARRIER: _____WORK#: _____EMAIL ADDRESS: _____

MOM LAST 4 SS #: _____ MAKE/MODEL OF CAR; _____LICENSE PLATE: _____

DAD CELL #/CARRIER: WORK#: EMAIL ADDRESS: _____

DAD LAST 4 SS #: _____ MAKE/MODEL OF CAR; LICENSE PLATE: _____

ARE THERE ANY CUSTODY RESTRICTIONS? Yes___ No___ (If Yes, please explain.) ----------

ARE CUSTODY DOCUMENTS ON FILE WITH THE CENTER? Yes No n/a_____

NAME, ADDRESS, PHONE NUMBER, DL # & RELATIONSHIP TO THE CHILD, FOR THE PERSON TO CALL IN CASE OF EMERGENCY, IF PARENTS CANNOT BE REACHED:
Name: _____Address: _____

Phone Number: _____Driver's License number: _____Relationship: _____

I hereby authorize the Children's Spot to allow my child to leave the center **ONLY** with the following persons. **(Please list the NAMES, PHONE NUMBER & DL NUMBER for each.)**
**Children will only be released to a parent or a person designated by the parent/guardian or person designated by the parent/guardian after verification of ID. Names must be added by the parent/guardian in person.
(ADDITIONS OR CHANGES CAN BE MADE VIA EMAIL info@childrensspot.net OR IN PERSON)

MOM: _____Phone#_____DL#_____

DAD: _____Phone#_____DL#_____

Name: _____Phone#_____DL#_____

Name: _____Phone#_____DL#_____

Name: _____Phone#_____DL#_____

Name: _____Phone#_____DL#_____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: _____ **Address:** _____
Phone: _____

Name of Emergency Medical Care Facility: _____
Address: _____ **Phone:** _____
Child's Insurance Information: Company: _____ **Policy Number:** _____
Policy Holders Name: _____

I give my consent for the facility to secure any and all necessary emergency medical care for my child.

(Parent/Guardian signature)_____ **Date:** _____

MEDICAL RELEASE:

The undersigned gives permission for AHA Educators dba The Children's Spot owners, employees, and/or agents to seek emergency medical treatment for the participant(s) in the event they are unable to reach any parent/guardian. The undersigned also agrees that they themselves will be responsible for any financial debt incurred by said action.

(Parent/Guardian signature) _____ **Date**_____

TRANSPORTATION: (Please circle all that apply)

I hereby ***GIVE*** ___***DO NOT GIVE*** ___consent for my child to be transported and supervised by the operation's employees for ***emergency care*** ____ ***on field trips*** ____***to and from school*** ____ ***(initial all that apply)***

(Parent/Guardian signature)_____ ***Date:*** _____

I understand that The Children's Spot has elected to be a fully vaccinated facility and that I am to provide proof of my child's vaccination record upon enrollment and when-ever it is updated with annual vaccinations.

(Parent/Guardian signature)_____ ***Date:*** _____

FIELD TRIPS: (Please circle all that apply)

I hereby ***give / do not give*** my consent for my child to participate in Field Trips.

Parent comments: _____

(Parent/Guardian signature)_____ ***Date:*** _____

ASSUMPTION OF RISK:

Participation in physical activities can involve motion, rotation, and height in a unique environment and as such carries with it a certain assumption of risk. The undersigned and the participant(s) choose to voluntarily enter upon said premises under the control of said limited liability company, knowing their present condition and knowing that said condition might become more hazardous and dangerous during the time the participant or the undersigned is upon said premises. The undersigned and the participant(s) voluntarily assume any and all risks of loss, damage, or injury that may be sustained by the participant(s) and/or the undersigned or any property owner by them while on or upon said premises above. The limited liability company may, but shall not be obliged to carry insurance on the participant(s) and the existence of insurance shall not change, alter, or increase the liability of the LLC to the participant(s) and the undersigned or affect the terms of this

Release. In signing the Release, the undersigned acknowledges:

A. That they have read thoroughly, understands completely the terms of Registration and Release, and signs it voluntarily.

B. That the undersigned signing either for themselves, or as Legal Guardians, is, in fact, the true and legal guardian and has the consent of the participant(s).

***Parent/Guardian signature)*_____ *Date:* _____**

PHOTO RELEASE:

This Photo Release Waiver is made by and between _____ being the legal parent/guardian of _____ and AHA Educators, Inc. dba The Children's Spot) located at 1222 E. Debbie Lane, Mansfield, TX 76063.

Please initial all that apply:

_____You voluntarily give AHA Educators dba: The Children's Spot consent and authorize the use of all photos, videos, etc. with your child's image. They are the property of The Children's Spot. You release all liability from officers, employees and corporate capacities from any and all claims. You have read and fully understand the provisions of this Photo Release Form and freely, knowingly and voluntarily enter into this Agreement.

_____ You want your child's photo/videos be sent to you via **BRIGHTWHEEL ONLY**

***(Parent/Guardian signature)*_____ *Date:* _____**

WATER ACTIVITIES: (Please circle all that apply)

I hereby *give / do not give* my consent for my child to participate in Water Activities such as: ***sprinkler play / splashing wading pools / water table play/ swimming pool (School Age Only).***

***(Parent/Guardian signature)*_____ *Date:* _____**

I ACKNOWLEDGE THAT I HAVE REVIEWED THE CENTER'S OPERATIONAL POLICIES at www.childrensspot.net (forms). (Please initial next to each topic to confirm that you have been made aware.)

___Parent Policies: including Return of tuition fees, Late fees, Failure to notify center of no school Pick-up fee, *(CCMS does not cover any of these fees. They are your responsibility and due in full on the date they are billed.)*

___Supply fees, annual registration fees.
___Parent Dress Code
___Discipline & guidance
___No Cell Phone usage on campus
___Illness & exclusion criteria
___Emergency plans
___Meals & food service practices
___Procedures for Drop-off & Pick-up
___Three strike policy (suspension & expulsion)
___Immunization requirements
___30 minute pick-up window for illness or behavior
___ Procedures for conducting health checks
___Procedures for parents to discuss concerns with the director
___Promotion of indoor & outdoor physical activity including criteria for extreme weather conditions
___Procedures for parents to participate in operation activities
___Procedures for release of children
___Official With-drawl
___Procedures for dispensing medications
___Unexpected Closures
___Procedures to visit the center without securing prior approval
___Procedures for supporting inclusive services
___Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline & CCL

***(Parent/Guardian signature)*_____ *Date:* _____**

I understand that my child must be in care by 9am (unless I have provided a doctor's note) to attend the morning session of care. If not in attendance by 9am my child can be dropped off at 2:30pm after nap for the afternoon session of care.

***(Parent/Guardian signature)*_____ *Date:* _____**

I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE: (please circle all that apply)
breakfast / am snack / lunch / pm snack

Does your child have diagnosed food allergies? Yes ___ No ___
F.A.R.E Act/Food Allergy Emergency Plan Submitted? Date_____
Provided Dr.'s note explaining why your child cannot participate in USDA Food Program Date:_____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA information line at (800)514-0383 (voice or (800) 514-0383 (TTY)

***(Parent/Guardian signature)*_____ *Date:* _____**

Child's Special Care Needs: (check all that apply)

___Environmental allergies
___Food Allergies/Intolerances
___Existing Illness
___Previous serious illness
___Injuries and hospitalizations (past 12 months
___Medications prescribed for continuous long-term care
___Limitations or restrictions on child's activities
___Reasonable accommodations or modifications
___ Adaptive equipment (include instructions below)
___Symptoms or indications of complications
___ Other (**If there is a special diet needed for your child, we will need a doctor's note outlining details.)

Explain any needs selected above:

_____
_____
_____
_____
_____
_____

School-Age Children

My child attends the following school:
Name of School: _____ Phone # of school _____

My child has permission to (check all that apply)
___Walk to or from school to home ____ride the bus
___be released to the care of his/her sibling under 18 years old
___If my child does not meet the Texas Seat Belt Guidelines, I will provide a booster seat to stay on the bus throughout the school year, labeled with my child's name and the name of his/her school.

***Parent signature:* _____ *Date:*_____**

Gang Free Zone:
Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

*(Parent/Guardian signature)*_____ *Date:* _____

HHSC (Department of Human Services) values your privacy. For more information, read our privacy policy on line at: https://hhs.texas.gov/policies-practices-privacy#security.

MORE ABOUT YOUR CHILD:

Sibling Names:

_____

Pets: _____

Has your child had previous experience in out-of-home daycare? _____ *Full-time/Part-time*
If so, was the experience successful? _____ If there were difficulties, please describe: _____
_____

Does your child understand what is said to him/her? _____ Is his/her speech clear? _____

Is your child toilet trained? YES ___ NO ___ Where are they in the process? (Describe the steps you have taken at home.)
_____
_____
_____

Does your child accept correction easily? _____ What type of discipline and/or positive reinforcement is used in the home? _____
_____

Please take some time and tell us about your child's personality, likes/dislikes, etc. The more you are able to share with us, the easier it will be for us to help your child adjust to his/her new surroundings.
_____
_____
_____
_____
_____
_____

Does your child have any emotional fears? _____ If so, what and how do you deal with them at home?
_____

Has your child exhibited a dominant hand preference (circle the one that apply) LEFT / RIGHT / BOTH.

SPECIAL NEEDS:

List any special needs/problems that our child may have such as, allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:
_____
_____
_____

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of the Title III, you may call the ADA Information line at (800) 514-0301 (voice) or (800) 514-0383 TTY).

(Parent/Guardian signature) _____Date_____

LIABILITY RELEASE:

In consideration of allowing the previously declared participant(s) to begin participation in The Children's Spot Childcare activities, while on the premises and property of said Center, the undersigned, for themselves, and/or being the legal and acting guardian of participant(s), acting for themselves and on behalf of the participant(s), release and hold harmless AHA Educators LLC dba The Children's Spot, it's owners, employees, and agents of and from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by the participant and/or the undersigned while in or upon the premises upon which The Children's Spot Childcare is conducted, or any premises under the control and supervision of AHA Educators LLC, it's owners, officers, employees, or agents or in route to or from any of the said premises, or while at any premises or place where activities sponsored by or participation in by AHA Educators dba The Children's Spot Childcare, it's owners, officers, agents or employees

(Parent/Guardian signature) _____Date_____

****A copy of this form will be carried with a Children's Spot staff member when transporting your child.**

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: RIGHT FROM THE START NUTRITION Agreement Number: 03132

Facility/Provider Name: The Childrens Spot 1169

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date / Birth - 5 months	Today's Date / 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date / 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped: _____

Work Telephone Number: _____ Emergency Telephone Number: _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑
	❑	❑

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no case number ❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * __ __ __ __ ❑ I do not have a Social Security Number

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ **to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ *(initial)* Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

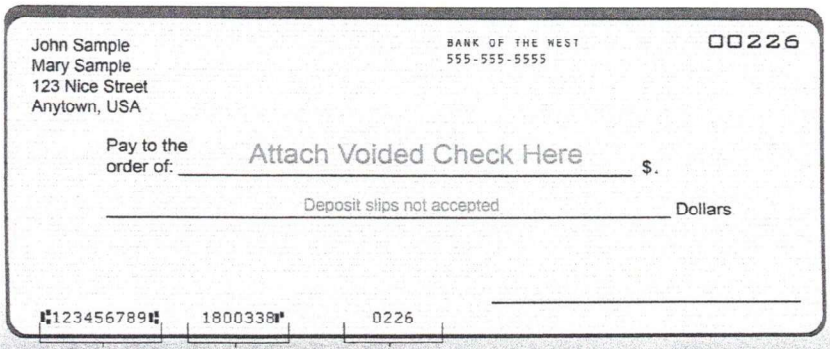
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

Texas Dept of Family
and Protective Services

ADMISSION INFORMATION

Form 2935
Aug 2010 / Pg 1 of 3

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.
3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.
4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ _____
Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature -- Parent or Legal Guardian Date

Rabbits in the Hole Story

In the forest there were little rabbits that went to a little rabbit school. One day the teacher rabbit told the little rabbits about woodcutters who came and cut down the forest trees., "When the trees fall down it is not safe for the little rabbits," she said, "so they need to hide behind or under the surrounding rocks. So little bunnies, when you hear someone say the special words. "Rabbits in the Hole!", run fast as you can into your hole under the rocks where it is safe".

The little bunnies listened to their teacher rabbit and even practiced going into their holes under the rocks. Then one day, the woodcutters came into the forest land started cutting down the trees! The teacher rabbit called out "Rabbits in the Hole!" and all the little rabbits ran into their holes under the rocks, where it was safe. They did such a fantastic job, that not a single little rabbit got hurt.

An emergency is when something happens that we do not expect and we have to act quickly to keep ourselves safe. When we hear a siren from a police car or a fire truck, that siren is telling us that there is an emergency and help is on the way.

Did the bunnies fight over the rocks or help each other be safe? They helped each other and there was no fighting or arguing or hogging! Let's pretend you hear a teacher say, "Rabbit in the Hole! Rabbits in the Hole!. " You need to hurry to a hiding place and stay there very quietly until I tell you to come out.

TO: ALL PARENTS OF THE CHILDREN'S SPOT

FROM: ASHLEY SHUFFIELD, OWNER/DIRECTOR

RE: "RABBIT IN THE HOLE"

Today at The Children's Spot, we performed the "Rabbit in the Hole" Lockdown drill. The purpose of this drill is to familiarize the children in case of an emergency due to an intruder, hostage incident, terrorism event, or any other disturbance that could cause them harm.

The following is how it is performed (as stated in our Operations Manual for staff):

- The director or person in charge will announce over the intercom "RABBITS IN THE HOLE" and will call 9-1-1
- Upon hearing this or sooner if you are aware that an intruder has entered the building or immediate vicinity, say calmly to the children, "Rabbits in the Hole, boys and girls. Rabbits in the Hole". The children will know what to do because you practice this every month. (CHILDREN HAVE BEEN GUIDED TO A CLOSET).
- Get your Attendance/Transition Sheet and stuff it in your clothing.
- Close all classroom doors and lock them if possible.
- Turn off the lights.
- If you have reason to believe that no one else in the center is aware of the danger, and you can safely do so, use the intercom to calmly announce, "Rabbits in the Hole. Rabbits in the Hole."
- Whisper and remind the children that, "We have to be VERY quiet."
- Perform a Name/Face check silently.
- Keep the children and yourself safe, in place, and away from all windows.
- ***Watch the children, not the situation!***
- ***If the intruder enters your classroom, do not argue with him.***
- The director or person in charge will ensure that all building entrances and exits are locked and that no unauthorized individuals leave or enter the building.
- Await further instructions from the director or person in charge or emergency personnel. The "ALL CLEAR!" will be announced over the intercom from the Director.

We have installed commercial dead bolt locks on all doors of the classrooms, library, office, and teacher's lounge. THESE WILL ONLY BE USED IN THE EVENT OF A LOCKDOWN DRILL.
I just wanted to inform you of this in case your child states we have "locked them in a closet". I hope we NEVER have to perform this procedure BUT we are prepared if necessary. I have attached the story that we have read, over and over, to the children so they are familiar with why we are having this drill monthly. It is so sad that we have to do this but we must be prepared. The Independent School Districts performs this as well. If you have any further questions or concerns, please see me in the office or call me at (817) 239-2740.

X

PARENT, GUARDIAN, OR CUSTODIAN

THE CHILDREN'S SPOT

WHERE OUR FUTURE CAN LEARN AND GROW

LIMITED AVAILABILTY

817-473-0441

1222 E. Debbie Ln. Mansfield, TX 76063

www.childrensspot.net