TOP TOTS
LEARNING CENTER

Where great starts never end

2023-2024

Family Enrollment Package

Toddlers

Welcome and Table of Contents

Thank you for entrusting TOP TOTS Learning Center to care for and educate your child. We are honored and humbled by this privilege. In order to enroll your child at TOP TOTS, we require parents and/or guardians to complete the following forms and provide as detailed information as possible. The enclosed forms are provided as PDF templates that will enable you to enter information directly from your computer. While you are welcome to print and complete these forms by hand, we strongly encourage you to complete these forms on your computer to ensure legibility and reduce chances for error. If you wish to jump directly to any particular form, you can click on each hyperlink below.

Once your forms are complete, our TOPT TOTS team will schedule an in-person meeting to review the information you provided, answer any questions you might have, and work with you to develop an individualized developmental plan, care plan, etc. for your child.

In addition to completing the forms listed above, you will also be required to provide copies of relevant documents pertaining to your child, special family circumstances, etc. These documents include, but may not be limited to:

- ✓ Documentation that a physical exam has been conducted by a licensed healthcare provider within twelve (12) months prior to enrollment*
- ✓ Documentation demonstrating that your child is current on immunizations required by the Commonwealth of Massachusetts for entry into Early Education and Care Programs, or Preschool for children two (2) years and older (unless exempt for religious reasons and/or a signed letter by a licensed healthcare provider is provided):
  - ✓ Four (4) or more doses of dipthera, tetanus, and pertussis (DTaP) vaccine
  - ✓ Three (3) or more doses of polio vaccine
  - ✓ One (1) or more doses of measles, mumps, and rubella (MMR) vaccine
  - ✓ One (1) to four (4) doses of haemophilus influenzae type b (Hib) vaccine (depending on the age when doses were received)
  - ✓ Three (3) doses of hepatis B vaccine, or laboratory evidence of immunity
  - ✓ One (1) dose of varicella (chickenpox) vaccine, or physician-certified history of chickenpox disease, or laboratory evidence of immunity
- ✓ Copies of any relevant court orders, joint custody agreements, visitation schedules, active restraining orders, etc that are signed by a judge and both parents/guardians.
- ✓ Documentation related to medication, as discussed in the Individual Health Care Plan and Medication Consent forms

*These records must be updated at least on annual basis, or when new medications and/or immunizations are given, or whenever your child's health status changes.

INFORMED CONSENT

Child's First Name: _____ **Child's Last Name:** _____

Access to TOP TOTS

While I will have access to TOP TOTS Learning Center (herein after, the "Center" or "TOP TOTS") without notice when my child is present, this access may not be used to supplement any visitation schedule or custody arrangements.

I Agree: ☐ **I Do Not Agree:** ☐

Release of my Child

For my child's safety, I understand that TOP TOTS will release him/her only to parent(s) or legal guardian(s) or to the third parties I have authorized on the TOP TOTS Child Information Form. Third party pick-up is subject to the following rules:

1. At least two (2) people other than parents and/or guardians must be designated as emergency contacts in the TOP TOTS Child Information Form. In the event of an emergency, emergency contacts will be contacted if parents and/or guardians cannot be reached.
2. If the person picking up my child from TOP TOTS is listed in the TOP TOTS Child Information Form, but does not regularly pick him/her up, I will verbally notify TOP TOTS in advance. Verbal authorization is not permitted for anyone who is not listed on the TOP TOTS Child Information Form.
3. If the person picking up my child is not listed on the TOP TOTS Child Information Form, I will notify TOP TOTS in writing, in advance.
4. Government-issued photo identification will be required if the third party does not regularly pick up my child, or is unknown to TOP TOTS staff.

I accept that TOP TOTS Learning Center will not release my child to anyone who appears to be impaired or under the influence of intoxicating substances. If an impaired person attempts to pick up my child, pick up will be refused and TOP TOTS staff will first attempt to contact the other parent and/or guardian, and then the other individuals listed on the TOP TOTS Child Information Form. If alternative pickup arrangements cannot be made after attempting to contact the parents/guardians and/or other authorized individuals, the Massachusetts Department of Families and Children (DCF) and/or Brookline Police Department will be called, as required by the Commonwealth of Massachusetts.

I Agree: ☐ **I Do Not Agree:** ☐

Walk Permission

When weather permits, TOP TOTS students may go on walks that are supervised by our staff, in the surrounding area of Brookline. Infants and toddlers will be transported in a buggy or a stroller.

I give permission for my child to participate in supervised walks while he/she is in the care of TOP TOTS staff. I further give permission for TOP TOTS staff to apply sunscreen to my child as necessary.

I Agree: ☐ **I Do Not Agree:** ☐

Note: At a future time, students of Pre-School and Pre-K age may take field trips. If/when a field trip is planned, a separate **Field Trip Permission Slip** that describes the activity will be provided for parental and/or guardian signature.

Photography & Video Permission

TOP TOTS Learning Center regularly takes photographs and videos of children who are enrolled in our Learning Center. However, TOP TOTS ensures that any use, display, or dissemination of photographs or videos of children is accomplished in a safe and thoughtful manner. These photographs or videos may be shared with you and other families in a variety of ways, such as on the TOP TOTS website or brochures, via email communications, on postings at our Center, or in parent newsletters. These photographs and/or videos may also be used to communicate with families to highlight our students' development, to illustrate the daily curriculum, or to document other activities associated with the Center. Additionally, photographs and/or videos may be used for other Centers, general business, and marketing purposes and may appear online. TOP TOTS retains all rights, title, and interest in these materials and may use and disseminate them in a variety of safe and thoughtful ways, in its sole judgement.

Please select one below:

☐ I give permission for TOP TOTS Learning Center to take photographs and videos of my child and use these documentations as described above.

☐ I give permission for TOP TOTS Learning Center to take photographs and videos of my child and to only use those documentations for curriculum purposes, documenting my child's progress, and for communication with me, our family, and other families with children who are currently enrolled in TOP TOTS.

Child Illness

TOP TOTS will call me if my child becomes ill, and I may be required to pick up my child as soon as possible (within 60 minutes). And, my child must remain out of the Center until he/she is free of symptoms for 24 hours, unless I provide a doctor's note stating that my child is 1) not contagious, and 2) can participate in group care. The TOP TOTS Parent and Family Handbook contains our full Child Illness Policy, and includes protocols for contagious illnesses.

I Agree: ☐ **I Do Not Agree:** ☐

Child Injuries

If my child sustains a minor injury during his/her care at TOP TOTS, I will receive an Occurrence Report that describes the incident when I pick him/her up on the day the injury occurred. I will be contacted immediately if the injury results in any swelling, involves the face or head, or requires medical attention.

I Agree: ☐ **I Do Not Agree:** ☐

Emergency Medical Care

If my child requires emergency medical attention while at TOP TOTS, the Center will attempt to contact me or the emergency contacts I provided on the TOP TOTS Child Information Form. If necessary, I authorize TOP TOTS Learning Center to call an ambulance to transport my child to the nearest medical facility for treatment, which will be either: 1) Boston Children's Hospital (300 Longwood Avenue, Boston MA 02115), 2) Beth Israel Deaconess Medical Center (330 Brookline Avenue, Boston MA 02115), or 3) Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115).

I Agree: ☐ **I Do Not Agree:** ☐

If my child requires emergency medical attention while at TOP TOTS, I request TOP TOTS to transport my child to the following medical facility:

Administration of First Aid, Cardiopulmonary Resuscitation (CPR), and Health and Medical Information

TOP TOTS staff members are trained in pediatric first aid and CPR. I authorize TOP TOTS staff to administer First Aid and CPR to my child if required. Further, my child's health information may be viewed by TOP TOTS staff, may be shared with emergency medical providers, and may be viewed by Commonwealth of Massachusetts licensors for compliance

I Agree: ☐ **I Do Not Agree:** ☐

Allergies

If my child has allergies, I agree to inform TOP TOTS Center Director and list the allergen, triggers, and treatment information on my child's Individual Health Care Plan. Due to severe nut allergies, I agree to refrain from bringing items containing nuts to the center. If my child has severe allergies that may require a medical response (such as an EpiPen), I will provide any device to TOP TOTS together with training for same.

I Agree: ☐ **I Do Not Agree:** ☐

TOP TOTS Learning Center Parent and Family Handbook Acknowledgement

I acknowledge and agree that 1) in addition to this Informed Consent, I received the TOP TOTS Learning Center Parent and Family Handbook, as well as any Center-specific information and relevant Commonwealth of Massachusetts policies, 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with TOP TOTS management and staff, and 3) I will abide by these materials.

I Agree: ☐ **I Do Not Agree:** ☐

I have read, understand, and accept the conditions noted above:

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: _____ **Date:** _____

CLICK HERE to upload your child's photo

CHILD AND FAMILY INFORMATION FORM

Child's Full Name:		Preferred Name/ Nickname:	
Date of Birth:		Gender:	
Place of Birth:		Height (inches):	
Weight (lbs):		Eye Color:	
Hair Color:		Identifying marks (if any):	
Primary language spoken at home:		Primary language spoken by child:	

Desired Start Date:	
Sibling 1 (enrolled at TOP TOTS):	
Sibling 2 (enrolled at TOP TOTS):	

Parent and/or Guardian Information

Parent/Guardian 1 Full Name:		Relationship to Child:	
Home Phone:		Email:	
Home Street Address:		Home City:	
Home State:		Home Zip Code:	
Company/Business Name:		Company/Business Address	
Company/Business Phone:		Company/Business Email:	

If parental custody is shared, please describe the arrangements here:	

Note: If any court-ordered parental custody, visitation rights, etc. have been established you must provide signed copies of the relevant documents to TOP TOTS (these can be uploaded to Brightwheel)

Parent/Guardian 2 Full Name:		**Relationship to Child:**	
Home Phone:		**Email:**	
Home Street Address:		**Home City:**	
Home State:		**Home Zip Code:**	
Company/Business Name:		**Company/Business Address**	
Company/Business Phone:		**Company/Business Email:**	

I/we authorize the following individuals (who are not parents and/or guardians) to drop off and/or pick up my child from TOP TOTS:

Authorized Individual	Relationship	Phone	Address

NOTE: If a person who is not listed above must pick up your child from TOP TOTS, you must notify TOP TOTS in advance, and in writing. Before TOP TOTS will release your child to any individual who is not listed above, government-issued photo identification must be presented to TOP TOTS staff.

The Following Individuals are Emergency Contacts (other than parents/guardians). In the event my child is involved in an emergency, TOP TOTS should reach out to these individuals (listed in priority order) if a Parent and/or Guardian Cannot be reached.

	Emergency Contact	Relationship	Phone	Address
1				
2				
3				
4				

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: _____ **Date:** _____

CLICK HERE to upload your child's photo

TODDLER DEVELOPMENTAL HISTORY & PERSONAL CARE

Child's Full Name:		**Preferred Name/Nickname:**	
Date of Birth:		**Gender:**	

Family Information: please provide names of family members (including pets) who live at home

Family Member	Relationship	How Does Your Child Address Them?

If you speak a primary language at home other than English, please share some words and/or phrases in your primary language that correspond to:

Phrase	Corresponding Phrase in Child's Primary Language
I'll take good care of you	
You are safe	
Mommy is coming soon	
Daddy is coming soon	
Time to use the bathroom	
Time to wash our hands	
Time to play	
Time to go outside	
Time to take a nap	
Time to eat a meal or snack	
Any other important phrase(s) not listed here	

My Child's Developmental & Health History

Developmental Milestone	YES	NO	Age he/she Started
Does your child crawl?			
Does you child walk with support?			
Does your child walk without support?			
Does your child babble?			
Does your child say audible words?			
Can your child speak 2-3 sentences?			
How does your child communicate needs?			
Please describe any serious illnesses or hospitalizations:			
Please describe any developmental concerns (if any):			
Please describe any physical conditions or concerns (if any):			
Please describe any complications during birth (if any):			

If your child has any special needs, please describe:

My Child's Nutrition and Feeding History

If your child is drinking milk, how is he/she fed (check all that apply): Breast: ☐ Bottle: ☐ Cup: ☐

	Brand or Type	Amount (ounces)	Number of Feedings and Times of Day
Breast Milk			
Formula/Milk			
Juice			
Other			

My child eats with (check all that apply): Spoon: ☐ Fork: ☐ Fingers: ☐ Other: ☐

My child eats while (check all that apply): In a high-chair: ☐ At the table: ☐ Other: ☐

If your child is breast fed, please describe your routine:

What are your child's favorite foods and eating preferences?

If your child has any special dietary requirements or restrictions, please describe them here:

What else should we know about your child's eating and drinking habits and preferences?

Please acknowledge "YES": For any diagnosed allergies, an Individual Health Care Plan must be completed and uploaded to Brightwheel. For any conditions that require administration of medication by TOP TOTS staff, a medication history/medication administration parental permission form must be completed and uploaded to Brightwheel ☐

My Child's Sleeping Routine

At home, my child sleeps in (check all that apply): A Crib: ☐ His/Her Own Bed: ☐ With Parents: ☐ Other: ☐

What time does your child go to bed at night?

What time does your child wake up in the morning?

Please describe the number and times of day your child naps:

Please describe your child's preferred sleeping position, and any pre-nap rituals that helps your child go to sleep:

Please describe any sleeping concerns you have for your child:

How to Comfort My Child

Does your child use a pacifier? Yes: ☐ No: ☐

Does your child suck his/her thumb?: Yes: ☐ No: ☐

If your child has a security object, please describe here:

How does your child like to be held? Please describe here:

Does your child have a "fussy time" and if so, how do you handle this?

How does your child communicate that they are uncomfortable?

What else would you like the TOP TOTS staff to know about comforting your child?

My Child's Diapering and/or Potty Routines

Is your child toilet trained? Yes: ☐ No: ☐

What is your child toilet trained for (urination, bowel, both)?: N/A

Does your child wear diapers during the day? Yes: ☐ No: ☐

Does your child wear diapers while napping? Yes: ☐ No: ☐

At what age did your child start using the toilet (months)?

What type and size diapers will you be providing?

What is used for home toileting (potty chair, special seat, regular toilet seat, other?

Typical number of urinations per day:

Words used for urination:

Typical number of bowel movements per day:

Words used for bowel movements:

What else would you like TOP TOTS to know about your child's diapering and/or potty routines?

My Child's Social Relationships

If your child has had any experience with child or group care, please describe here:

How is your child around other children (friendly, aggressive, shy, other)?

How does your child react to new situations, children, and adults?

What are your child's favorite toys to play with and things to do?

What does your child like to read or have read to them?

If your child is afraid of anything, please describe here:

Our team at TOP TOTS Learning Center aims to be your partner of choice, wants you to feel like he/she is on TOP while in our care, and wants him/her to achieve their TOP potential in life. As such, we'd like to understand a bit more about. . .

Please explain your general parenting philosophy

What do you, as a parent, and as a family, hope your child gets out of his/her experience at TOP TOTS?

Please share any other relevant information, not covered yet, that you think we should know:

Primary Physician/Health Care Provider Information:

Physician/Primary Health Care Provider Name:		**Name of Clinic/Hospital:**	
Street Address:		**City:**	
State:		**Zip Code:**	
Phone Number:		**Email:**	

Dentist Information:

Dentist Name:		**Name of Dental Clinic:**	
Street Address:		**City:**	
State:		**Zip Code:**	
Phone Number:		**Email:**	

Health Insurance Information:

Health Insurance Provider:	
Health Insurance Policy Number:	

I attest that the information I have provided on this Developmental History and Personal Care form is accurate.

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: _____ **Date:** _____

CLICK HERE to upload your child's photo

SUSPECTED ALLERGY & FOOD INTOLERANCE FORM

Please complete this form if you suspect your child may be allergic to a substance, product, or has a food intolerance but *has not* received a confirmed medical diagnosis by a licensed medical provider. If a suspected allergy or food intolerance is medically diagnosed, an Individualized Health Care Plan Form must be completed, signed by your licensed medical provider, and provided to TOP TOTS. This form must be updated on an annual basis or, whenever there is any change in treatment or if your child's condition changes.

Child's Full Name: **Date of Birth:**

My child has a suspected allergy to:

My child has a suspected food intolerance to:

I suspect and/or am concerned that my child may be allergic for the following reasons (check all that apply):

☐ No previous exposure ☐ Family history

Previous reaction (please explain and provide the date of the reaction)

Other

I understand that TOP TOTS Learning Center requires up-to-date information regarding my child's suspected allergy and/or food intolerance. I also understand that for my child's safety, his/her photograph and allergy information will be posted in the classrooms, kitchen and/or food storage area.

Parent/Guardian Signature: **Date:**

To eliminate the suspected allergy or food intolerance please complete the following:

I, (parent/guardian's name) _____ acknowledge that (child's name) _____ no longer has a suspected allergy to _____ and may now be served these item(s) while at TOP TOTS Learning Center.

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: **Date:**

CLICK HERE to upload your child's photo

INDIVIDUAL HEALTH CARE PLAN

This Individual Health Care Plan must be updated annually, or whenever there is any change in treatment, or if the child's condition changes. For complete medication administration information, please complete the Medication Authorization Form with your child's physician or health care provider.

Child's Name:		**Date of Birth:**	
Parent/Guardian's Name:		**Parent Phone:**	
Physician's Name:		**Physician Phone:**	

Any change to the child's Health Care Plan? ☐ **YES** (indicate changes below) ☐ **NO** (updated physician and parental signature required)

CHRONIC HEALTH CARE CONDITION(S)

Name of Chronic Health Care Condition(s):

Description of Chronic Health Care Condition:

Symptoms:

Medical treatment(s) necessary while at program:

Potential side-effects of treatment(s):

Potential consequences if treatment(s) not administered:

Parent and/or Guardian and Healthcare Provider Acknowledgement Statement

To ensure the safety of your child, TOP TOTS cannot delete a health condition which has been previously documented unless we have a signed note from your child's licensed physician stating that he/she is no longer has that condition (or those conditions), nor can we add items or change any medication without a signed note from his/her licensed health care provider.

I understand that TOP TOTS Learning Center requires the most timely, up-to-date information regarding my child's health care condition(s). I also understand that the safety of my child, his/her photograph, and medical information will also be posted in the classrooms, kitchen, and/or food storage areas.

Parent/Guardian Signature: _____ **Date:** _____

Name of Physician (printed):

Physician Signature _____ **Date:** _____

TOP TOTS Director Signature: _____ **Date:** _____

TOP TOTS STAFF TRAINING:

TOP TOTS staff may be trained on my child's Health Condition(s) by:

The following staff have been trained on my child's medical condition and/or proper administration of medication:	**Date trained:**

Please check all that apply:

This Individual Health Care Plan was created by:

- ☐ Parent and/or guardian
- ☐ Physician or Licensed Healthcare Provider
- ☐ TOP TOTS Health Care Consultant
- ☐ Other:

This Individual Health Care Plan is maintained by:

- ☐ TOP TOTS Director
- ☐ TOP TOTS Assistant Director
- ☐ Child's educator
- ☐ Other:

This Individual Health Care Plan must be updated annually, or whenever there is any change in treatment, or if the child's condition changes. For complete medication administration information, please complete the Medication Authorization Form with your child's physician or health care provider.

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

CLICK HERE to upload your child's photo

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication:_____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____ _____ _____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- ☐ PARENT DROP OFF
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE/VAN
- ☐ PROGRAM BUS/VAN
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANS. ARRANGED BY PARENT
- ☐ OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

- ☐ PARENT PICK UP
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE/VAN
- ☐ PROGRAM BUS/VAN
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANS. ARRANGED BY PARENT
- ☐ OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- ☐ PARENT DROP OFF
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE/VAN
- ☐ PROGRAM BUS/VAN
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANS. ARRANGED BY PARENT
- ☐ OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

- ☐ PARENT PICK UP
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE/VAN
- ☐ PROGRAM BUS/VAN
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANS. ARRANGED BY PARENT
- ☐ OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

ORAL HEALTH CARE (TOOTHBRUSHING) CARE PERMISSION FORM

Child's First Name: _____ **Child's Last Name:** _____

As part of our daily program at TOP TOTS Learning Center, children will brush their teeth as recommended by the American Academy of Pediatrics (https://www.healthychildren.org/english/healthy-living/oral-health/Pages/default.aspx)

Tooth brushes and toothpaste will be provided by parents and/or guardians and should meet the following requirements:

- The recommended use on the label must be consistent with your child's age.
- All products require a valid expiration date, where applicable.
- All containers/tubes must be labeled clearly with your child's full name.

Please complete one of the following:

☐ I give TOP TOTS Learning Center permission to allow my child to brush his/her teeth while in their care

☐ I do not give TOP TOTS Learning Center permission to allow my child to brush his/her teeth while in their care.

Special Instructions

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: _____ **Date:** _____

TOP TOTS Learning Center requires Parents and/or Guardians to review and sign this Oral Care Permission on an annual basis.

SUNSCREEN AND INSECT REPELLANT PERMISSION

Child's First Name: _____ **Child's Last Name:** _____

Sunscreen and insect repellent should be applied to your child at least once at home to test for any potential allergic reaction.

Aerosols, sprays, and sunscreen/insect repellent combinations are prohibited at TOP TOTS. Sunscreen must provide UVA and UVB protection of 15 or higher.

Insect repellent may only be used if recommended by public health authorities, or requested by a parent/guardian. The repellent must contain a concentration of no more than 30% DEET (N,N-Diethyl-meta-toluamide). Oil of lemon eucalyptus and para-methane products may not be used on children under 3 years of age.

All sunscreen and insect repellent provided by parents/guardians must be:

- Provided in the original container
- Clearly labeled with your child's full name and date provided
- Within the expiration date
- Appropriate for the age of your child
- Free of nut ingredients.

Please complete one of the following:

I give TOP TOTS Learning Center permission to apply (name of sunscreen) _____ and/or (name of insect repellant) _____ to my child when outdoor conditions warrant, and in a manner consistent with package instructions (subject to any special instructions I provide below).

I do not give TOP TOTS Learning Center permission to apply ____ sunscreen and/or ____ insect repellant to my child. I do not hold TOP TOTS Learning Center, LLC responsible for my decision and understand that my child may be sunburned/bitten as a result. I understand that I should provide protective clothing including a hat, lightweight long sleeve shirt and pants instead, to protect my child from sun exposure and insects during outdoor activities.

Special Instructions

Sunscreen: _____

Insect Repellant: _____

Parent/Guardian Signature: _____ **Date:** _____

TOP TOTS Director Signature: **Date:**