Gilbert Campus
580 W. Melody Ave.
Gilbert, AZ 85233
480-813-9537 phone
480-813-6742 fax

IB World School

EDUPRIZE SCHOOLS

EDUPRIZESCHOOLS.NET

Queen Creek Campus
4567 W. Roberts Rd.
Queen Creek, AZ 85142
480-888-1610 phone
480-888-1655 fax

A+ School of Excellence

I have read, understand and agree to abide by the policies and procedures in the Pre-K Parent/Student Handbook.

I also understand that EDUPRIZE reserves the right to terminate enrollment for the following reason but not limited to:

- Failure to pay
- Routinely late pick up
- Failure to complete the required forms
- Lack of parental co-operation
- Not toilet trained
- Failure of child to adjust after a reasonable amount of time
- Physical or verbal abuse of any person or property
- Our inability to meet the child's needs
- If child creates a hazardous environment due to behavior or bodily fluid
- Lack of compliance with policy and regulations
- Serious illness of child

_____
Student Name

_____ _____
Parent/Guardian Name – Print Date

_____
Parent/Guardian Signature

Please return signed and dated form within 7 days of enrollment.

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Photo Release Permission

EDUPRIZE Pre-K program will take opportunities to highlight our students and program for promotional purposes. Please let us know if you approve or not.

I give permission for EDUPRIZE to release photography/videos of my child. Please check the appropriate box. By checking NO, your child will not be pictured in the yearbook either.

☐ Yes ☐ No

Student Name: _____

Program: AM PM M-F T/Th M/W/F (please circle all that applies.)

Parent Signature: _____ Date: _____

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.

****

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.