PROMISE LAND
LEARNING CENTER

WELCOME LETTER

Welcome to Promise Land Learning Center, a ministry of Living Branch Church. The foundation of our center is established on the belief in our Lord and Savior Jesus Christ and Him Crucified.

Our teachers have a love for the work they do and demonstrate that love through the daily activities provided. All of our staff receive a minimum of 30 hours of training per year. Training classes focus on child growth and development, guidance and discipline, age-appropriate curriculum, teacher-child interaction, and much more. Our staff is certified in CPR and first aid.

Your child's acceptance and placement in a class is conditional upon the date and time Promise Land Learning Center receives all items listed below.

ALL students must complete this enrollment process. We ask that you submit the following items all together:

☐ The **REGISTRATION PACKET** must be completed in its entirety with all necessary signatures. Emergency contacts and most of the information collected in the registration paperwork, are a requirement of the state, and must be provided. Allergy/dietary restriction forms are due at the time of enrollment.

☐ **COMPLETED HEALTH RECORDS:** All health records must be updated once a year to meet state guidelines. We require all health records to be submitted with the registration packet to complete the process promptly.

☐ **DOCTOR'S RELEASE FORM:** This document (or one similar) must be signed and dated by a physician, another requirement of the state. It can be mailed, faxed or brought in.

☐ **SHOT RECORDS:** Our records must be updated each time a child is immunized. This typically occurs at 2 mos., 4 mos., 6 mos., 12 mos., 15 mos., 18 mos., 2 yrs., 3 yrs. These may be faxed or emailed from the doctor's office or brought into the office.

☐ **HEARING AND VISION SCREENING** (4 and older) The results of your child's hearing and vision screening may be filled in the appropriate boxes on the Doctor's Statement of Health, or turned in on a separate form.

☐ **PAY THE REGISTRATION FEE ($100 per child) FOR ALL FAMILIES, AND SUPPLY FEE ($100).** The registration fee is required to reserve a child's spot in his/her class. It is separate from tuition, and is nonrefundable. Complete Tuition Express ACH/CC Autodraft Form for Tuition and Registration Fee.

☐ **BECOME FAMILIAR WITH OUR DATES & HOURS OF OPERATION:** Our regular hours during the school year are 6:30am to 6:00pm.

We are grateful for the opportunity to teach your children. Our job is to have fun while learning with focus on the Fruit of the Spirit: Love, Joy, Peace, Patience, Kindness, Goodness, Faithfulness, Gentleness, and Self-Control. (Galatians 5:22-23)

If you have any questions, concerns, or suggestions do not hesitate to speak with us. Our doors are always open to our parents.

Many Blessings, and Welcome!
Marie Johansson, Juli Voncannon, Lanie Kirsch

TEXAS Health and Human Services

Form 2935
October 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: Promise Land Learning Center		Director's Name: Marie Johansson	
Child's Full Name:		Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian *(if different from the child's)*:	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

◯ Yes ◯ No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

◯ Yes ◯ No

Do you want your child to wear a life jacket while in or near a swimming pool?

◯ Yes ◯ No

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Signature — Parent or Legal Guardian

Date Signed

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

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://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) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

9. School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

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

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

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. *(Select **only one** option.)*

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

◯ A signed and dated copy of a health care professional's statement is attached.

◯ 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.

◯ 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 submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature **Date Signed**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative 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.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature **Date Signed**

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: CHILD CARE PLUS Agreement Number: CE ID 02051

Facility/Provider Name: Promise Land Day Care Center 1325

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 reimubursement, 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.	

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 eligibility 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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Assessment Form

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date Signed

Additional Comments:

PROMISE LAND
LEARNING CENTER

Dear Families,

Thank you for choosing Promise Land for your child care needs. We are always looking for better ways to communicate with our families. One way we would like to expand is through pictures. We understand that your child has some very special moments while they are in our care, and we would love to be able to photograph these moments for you. Some examples would be infants learning to crawl or walk; wobbler/toddler climbing the slide, trying new foods and our class parties. With your permission we would take pictures of your child and post them in our center, send them to your email, post on our secured Facebook page, or even post them on our webs site page in activity pictures. As always, no personal information will be given with the pictures. Below you will find the permission slip to allow us to photograph your child, please check the appropriate boxes, sign the permission and return it as soon as possible.

I _____ give P.L.L.C permission to photograph
(Parent's Name)

my child _____ during their time at P.L.L.C.
(Child's Name)

Photo documentation will be facilitated by P.L.L.C. staff members or affiliates. I understand that these photos may be used in the future by P.L.L.C. for promotional and/or educational purposes.

I give ☐ I do not give ☐ permission for pictures of my child to be posted thought P.L.L.C.

I give ☐ I do not give ☐ permission for pictures of my child to be emailed to me _____
_____

I give ☐ I do not give ☐ permission for pictures of my child to be posted on P.L.L.C.'s secured Facebook page.

I give ☐ I do not give ☐ permission for pictures of my child to be posted in P.L.L.C.'s website page in activity pictures.

☐ I prefer not to have pictures taken of my child.

_____
Parent Signature

PROMISE LAND
LEARNING CENTER

DOCTOR RELEASE FORM

Date: _____

Name of Child: _____

Date of Birth: _____

This child is free of any communicable diseases, up to date on their immunizations, and able to participate in daycare/school.

Sincerely,

_____

Address: _____

_____

_____

Phone: _____

Fax: _____

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

PLACE PICTURE HERE

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.**

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

For **ANY** of the following **SEVERE** SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

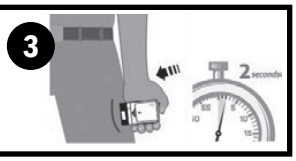
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

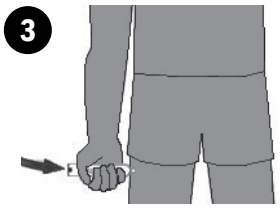
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



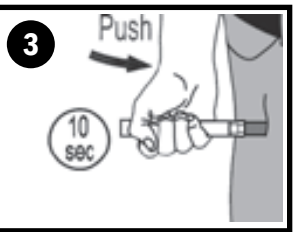
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



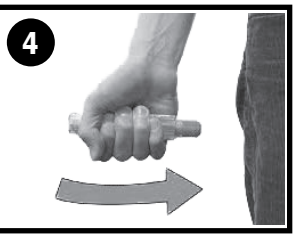
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Epinephrine first, then **call 911**. Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

2023 - 2024 Texas Minimum State Vaccine Requirements for Child-Care and Pre-K Facilities

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This chart is not intended as a substitute for consulting the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements for child-care facilities by the Human Resources Code, Chapter 42.

A child shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a child-care facility in Texas.

Age at which child must have vaccines to be in compliance:	**Minimum Number of Doses Required of Each Vaccine**							
	Diphtheria / Tetanus / Pertussis (DTaP)	**Polio**	**Hepatitis B (HepB)** [1]	***Haemophilus influenzae* type b (Hib)** [2]	**Pneumococcal conjugate vaccine (PCV)** [3]	**Measles, Mumps, & Rubella (MMR)** [1, 4]	**Varicella** [1, 4, 5]	**Hepatitis A (HepA)** [1, 4]
0 through 2 months								
By 3 months	1 Dose	1 Dose	1 Dose	1 Dose	1 Dose			
By 5 months	2 Doses	2 Doses	2 Doses	2 Doses	2 Doses			
By 7 months	3 Doses	2 Doses	2 Doses	2 Doses	3 Doses			
By 16 months	3 Doses	2 Doses	2 Doses	3 Doses	4 Doses	1 Dose	1 Dose	
By 19 months	4 Doses	3 Doses	3 Doses	3 Doses	4 Doses	1 Dose	1 Dose	
By 25 months	4 Doses	3 Doses	3 Doses	3 Doses	4 Doses	1 Dose	1 Dose	1 Dose
By 43 months	4 Doses	3 Doses	3 Doses	3 Doses	4 Doses	1 Dose	1 Dose	2 Doses

↓ Notes on the back page, please turn over. ↓

Rev. 02/2023

[1] Serologic evidence of infection or serologic confirmation of immunity to measles, mumps, rubella, hepatitis B, hepatitis A, or varicella is acceptable in place of vaccine.

[2] A complete Hib series is two doses plus a booster dose on or after 12 months of age (three doses total). If a child receives the first dose of Hib vaccine at 12 - 14 months of age, only one additional dose is required (two doses total). Any child who has received a single dose of Hib vaccine on or after 15 - 59 months of age is in compliance with these specified vaccine requirements. Children 60 months of age and older are not required to receive Hib vaccine.

[3] If the PCV series is started when a child is seven months of age or older or the child is delinquent in the series, then all four doses may not be required. Please reference the information below to assist with compliance:

- For children seven through 11 months of age, two doses are required.
- For children 12 - 23 months of age: if three doses have been received prior to 12 months of age, then an additional dose is required (total of four doses) on or after 12 months of age. If one or two doses were received prior to 12 months of age, then a total of three doses are required with at least one dose on or after 12 months of age. If zero doses have been received, then two doses are required with both doses on or after 12 months of age.
- Children 24 months through 59 months meet the requirement if they have at least three doses with one dose on or after 12 months of age, or two doses with both doses on or after 12 months of age, or one dose on or after 24 months of age. Otherwise, an additional dose is required. Children 60 months of age and older are not required to receive PCV vaccine.

[4] For MMR, Varicella, and Hepatitis A vaccines, the first dose must be given on or after the first birthday. Vaccine doses administered within four days before the first birthday will satisfy this requirement.

[5] Previous illness may be documented with a written statement from a physician, school nurse, or the child's parent or guardian containing wording such as: "This is to verify that (name of child) had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine." The written statement will be acceptable in place of any, and all varicella vaccine doses required.

Information on exclusions from immunization requirements, provisional enrollment, and acceptable documentation of immunizations may be found in §97.62, §97.66, and §97.68 of the Texas Administrative Code, respectively and online at https://www.dshs.texas.gov/immunize/school/default.shtm.

Exemptions

Texas law allows (a) physicians to write medical exemption statements which clearly state a medical reason exists that the person cannot receive specific vaccines, and (b) parents/guardians to choose an exemption from immunization requirements for reasons of conscience, including a religious belief. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (for example, a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem). Schools should maintain an up-to-date list of students with exemptions, so they may be excluded in times of emergency or epidemic declared by the commissioner of public health.

Instructions for requesting the official exemption affidavit that must be signed by parents/guardians choosing the exemption for reasons of conscience, including a religious belief, can be found at www.dshs.texas.gov/immunize/school/exemptions.aspx. The original Exemption Affidavit must be completed and submitted to the school.

For children claiming medical exemptions, a written statement by the physician must be submitted to the school. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

Documentation

Since many types of personal immunization records are in use, any document will be acceptable provided a physician or public health personnel has validated it. Validation includes a signature, initials, or stamp. An immunization record generated from an electronic health record must include clinic contact information and the provider's signature/stamp, along with the vaccine name and vaccination date (month, day, and year). An official record generated from a health authority is acceptable. An official record received from school officials, including a record from another state is acceptable.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services • Immunizations • MC-1946 • P. O. Box 149347 • Austin, TX 78714-9347 • (800) 252-9152

Stock No. 6-15 Rev. 02/2023

Requisitos mínimos de vacunación en el estado de Texas de 2023 a 2024 para centros de cuidado infantil y de prekínder

Esta gráfica resume los requisitos de vacunación incorporados en las secciones 97.61 a 97.72 del título 25 (Servicios de salud) del Código Administrativo de Texas (TAC). La gráfica no pretende sustituir la consulta del TAC, el cual contiene otras disposiciones y detalles. Según lo dispuesto en el capítulo 42 del Código de Recursos Humanos, se confiere al Departamento Estatal de Servicios de Salud (DSHS) la facultad de establecer los requisitos en materia de inmunización para los centros de cuidado infantil.

Los niños deberán presentar comprobantes de vacunación aceptables antes de inscribirse, asistir o ser transferidos a un centro de cuidado infantil en Texas.

Edad a la que el niño debe recibir las vacunas para cumplir con los requisitos:	**Número mínimo de dosis necesarias de cada vacuna**							
	Difteria / tétanos / tos ferina (DTaP)	**Polio**	**Hepatitis B (HepB)** [1]	***Haemophilus influenzae*, tipo b (Hib)** [2]	**Vacuna anti-neumocócica conjugada (PCV)** [3]	**Sarampión, paperas y rubeola (MMR)** [1, 4]	**Varicela** [1, 4, 5]	**Hepatitis A (HepA)** [1, 4]
De 0 desde 2 meses								
Antes de los 3 meses	1 dosis	1 dosis	1 dosis	1 dosis	1 dosis			
Antes de los 5 meses	2 dosis	2 dosis	2 dosis	2 dosis	2 dosis			
Antes de los 7 meses	3 dosis	2 dosis	2 dosis	2 dosis	3 dosis			
Antes de los 16 meses	3 dosis	2 dosis	2 dosis	3 dosis	4 dosis	1 dosis	1 dosis	
Antes de los 19 meses	4 dosis	3 dosis	3 dosis	3 dosis	4 dosis	1 dosis	1 dosis	
Antes de los 25 meses	4 dosis	3 dosis	3 dosis	3 dosis	4 dosis	1 dosis	1 dosis	1 dosis
Antes de los 43 meses	4 dosis	3 dosis	3 dosis	3 dosis	4 dosis	1 dosis	1 dosis	[2] dosis

↓ Notas al reverso, por favor dé la vuelta. ↓

Rev. 02/2023

[1] Una prueba serológica de infección o la confirmación serológica de inmunidad al sarampión, paperas, rubeola, hepatitis B, hepatitis A o varicela se aceptarán en lugar de la vacuna.

[2] Una serie completa de la vacuna Hib consta de dos dosis más una dosis de refuerzo a los 12 meses de edad o después (tres dosis en total). Si un niño recibe la primera dosis de la vacuna Hib entre los 12 y los 14 meses de edad, solo será necesaria una dosis adicional (dos dosis en total). Si un niño ha recibido una sola dosis de la vacuna Hib en o después de los 15 a 59 meses de edad, cumple con los requisitos de esta vacuna específica. Los niños mayores de 60 meses de edad no necesitan recibir la vacuna Hib.

[3] Si la serie de vacunas PCV se empieza a administrar cuando el niño es mayor de siete meses de edad, o si el niño se atrasó al recibir alguna dosis de la serie, entonces puede que no sean necesarias las cuatro dosis. Para ayudarse a cumplir con los requisitos, refiérase a la información siguiente:

- Para los niños de siete a 11 meses de edad, se requieren dos dosis.
- Para los niños de 12 a 23 meses de edad: si han recibido tres dosis antes de los 12 meses de edad, entonces deberán recibir una dosis adicional (para un total de cuatro dosis) a los 12 meses de edad o después. Si han recibido una o dos dosis antes de los 12 meses de edad, entonces necesitan un total de tres dosis, una de las cuales al menos deben recibirla a los 12 meses de edad o después. Si no han recibido ninguna dosis, entonces necesitan recibir dos dosis y ambas deberán recibirlas a los 12 meses de edad o después.
- Los niños de 24 a 59 meses de edad cumplen con los requisitos si recibieron al menos tres dosis, una de las cuales la recibieron a los 12 meses de edad o después; o dos dosis, ambas recibidas a los 12 meses de edad o después; o una dosis recibida a los 24 meses de edad o después. De lo contrario, es necesaria una dosis adicional. Los niños mayores de 60 meses de edad no necesitan recibir la vacuna PCV.

[4] Para la vacuna MMR y las vacunas contra la varicela y la hepatitis A, la primera dosis debe administrarse en el primer cumpleaños o después. Las dosis de vacunas administradas en los 4 días anteriores al primer cumpleaños satisfacen los requisitos.

[5] Si se ha padecido anteriormente la enfermedad, esto puede documentarse con una declaración por escrito de un médico, del personal de enfermería de la escuela, o del padre o tutor del niño, y debe contener una afirmación como la siguiente: "Mediante este documento confirmo que (nombre del niño) tuvo varicela el día (fecha), o alrededor de esta fecha, y no necesita la vacuna contra la varicela". Esta declaración por escrito será aceptable en lugar de cualquiera de las dosis requeridas de la vacuna contra la varicela.

La información sobre las exclusiones de los requisitos de inmunización, la inscripción provisional y la documentación aceptable de las inmunizaciones puede encontrase en las secciones 97.62, 97.66 y 97.68, respectivamente, del Código Administrativo de Texas, y en línea en https://www.dshs.texas.gov/immunize/school/default.shtm (en inglés).

Exenciones

La ley en Texas permite: (a) que los médicos declaren por escrito la exención médica, siempre que en ella se indique claramente que existe un motivo médico por el que la persona no puede recibir determinadas vacunas, y (b) que los padres o tutores opten por la exención de los requisitos de inmunización por motivos de conciencia, incluida una creencia religiosa. La ley no autoriza, sin embargo, a que los padres o tutores elijan la exención simplemente para evitarse molestias (por ejemplo, que se hubiera extraviado un registro o este estuviera incompleto, y para ellos fuera demasiado difícil acudir con un médico o a una clínica para corregir el problema). Las escuelas deben mantener una lista actualizada de los estudiantes con exenciones, con el fin de que puedan ser excluidos en el caso de una emergencia o una epidemia declarada por el comisionado de salud pública.

Podrá encontrar las instrucciones para solicitar la declaración jurada de exención oficial, que debe ser firmada por los padres o tutores que opten por la exención por motivos de conciencia, incluida una creencia religiosa, en www.dshs.texas.gov/immunize/school/exemptions.aspx (en inglés). La declaración jurada de exención debe llenarse y enviarse a la escuela en su versión original.

En el caso de los niños sujetos a exenciones médicas, es necesario presentar a la escuela una declaración por escrito del médico. A menos que en la declaración conste por escrito que existe un padecimiento médico de por vida, la declaración de exención es válida por solo un año a partir de la fecha en que la firmó el médico.

Documentación

Dado que se utilizan distintos tipos de registros personales de vacunación, cualquier documento será aceptable siempre y cuando un médico o el personal de salud pública lo haya validado. La validación incluye una firma, las iniciales o el sello. Un registro de vacunación procedente de un registro de salud electrónico debe incluir la información de contacto de la clínica o centro médico y la firma o el sello del proveedor, junto con el nombre de la vacuna y la fecha de vacunación (mes, día y año). Se acepta un registro oficial que provenga de una autoridad de salud. También se acepta un registro oficial que se haya recibido de funcionarios de la escuela, incluido un registro de otro estado.

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Stock No. 6-15 Rev. 02/2023

Promise Land Learning Center

13229 Hwy 105 West * Conroe, Tx * 77304

Phone: 936-588-3400 ext. #2, Fax: 936-588-3523

Monday – Friday - 6:30am to 6:00 p.m.

PRICE LIST FOR ALL CHILDREN

Registration Fee- $100.00 (per family) NON-REFUNDABLE Curriculum/Supply fee- $100.00 (per child)

Full time families with multiple children will receive a 5% discount off the oldest child

Tuition is due every Monday and late payment fees of $25.00 are applied on Wednesday at noon

Pick up late fee is $5.00 after 6 p.m. then $1.00 a minute after 6:05 p.m.

There will be a $35.00 fee on all returned checks

Infants	Wobblers	Toddlers
3-11mos	12-17mos	18-23mos
$260 per week	$240 per week	$235 per week
$56 per day	$52 per day	$52 per day

2 Year Olds	3 Year Olds	4 Year Olds
$220 per week	$220 per week	$220 per week
$52 per day	$52 per day	$52 per day

Pre-Kindergarten	Schoolers
$220 per week	MISD- $115 per week
$52 per day	CISD- $110 per week

Summer Camp (4-12 Year Olds)

4-5 Year olds - $220 per week

6-12 Year olds- $200 per week

Registration fee- $100 (per family)

Curriculum/Supply fee- $100 (per child)

Please sign:

Signature:_____Date:_____

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – an automatic payment processing system that allows 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) **Promise Land Learning Center** ☐ **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. 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.

SECTION A

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____

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

☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature

A service of procare SOFTWARE®

PROMISE LAND
LEARNING CENTER

SCRIPTURES FOR CHILDREN (TAKEN FROM THE BIBLE, AMPLIFIED VERSION)

Proverbs 22:6 - Train up a child in the way he should go [teaching him to seek God's wisdom and will for his abilities and talents], even when he is old he will not depart from it.

Psalm 127:3-4 - Behold, children are a heritage *and* gift from the Lord,
The fruit of the womb a reward.
Like arrows in the hand of a warrior,
So are the children of one's youth.

Isaiah 59:21 - "As for Me, this is My covenant with them," says the Lord: "My Spirit which is upon you [writing the law of God on the heart], and My words which I have put in your mouth shall not depart from your mouth, nor from the mouths of your [true, spiritual] children, nor from the mouth of your children's children," says the Lord, "from now and forever."

Isaiah 54:13 - "And all your [spiritual] sons will be disciples [of the Lord],
And great will be the well-being of your sons.

Proverbs 23:24 - The father of the righteous (in upright standing with God) will greatly rejoice, and he who becomes the father of a wise child will have joy in him.

Matthew 18:4-5 - Therefore, whoever humbles himself like this child is greatest in the kingdom of heaven. Whoever receives *and* welcomes one child like this in My name receives Me.

Isaiah 11:8-9 - And the nursing child will [safely] play over the hole of the cobra,
And the weaned child will put his hand on the viper's den [and not be hurt].
They will not hurt or destroy in all My holy mountain, for the earth will be full of the knowledge of the Lord as the waters cover the sea.

Jeremiah 29:11-13 - For I know the plans *and* thoughts that I have for you,' says the Lord, 'plans for peace *and* well-being and not for disaster, to give you a future and a hope. [12] Then you will call on Me and you will come and pray to Me, and I will hear [your voice] *and* I will listen to you. [13] Then [with a deep longing] you will seek Me *and* require Me [as a vital necessity] and [you will] find Me when you search for Me with all your heart.