



THE HEIGHTS CDC

CHILD DEVELOPMENT CENTER

Dear CDC Family,

The Heights Child Development Center uses Tuition Express to process tuition and fee payments safely, quickly and efficiently. All CDC families will be required to sign up for automated payments through Tuition Express. We will no longer accept cash or check for tuition payments. Tuition Express is a PCI Level 1 Service Provider, therefore your personal account information could not be safer.

We offer the following Tuition Express payment options:

- Automated Credit Card Transactions (VISA/MC only)
- Automated ACH Transactions

We are asking all families to complete the Tuition Express Parent Authorization Form and return it to us by August 1st. Once we have your completed form, your account information will be entered into our system and you will be set up for automated credit card or ACH transactions. This will allow us to collect payments from your credit card or bank account on the 1st of each month (or closest business day thereafter). Late fees will be assessed to any account that has not been updated or reconciled by the 10th of the month due to a decline in processing payments.

Please review the Tuition Express FAQ. There you will find answers to questions you may have regarding Tuition Express or automated payments in general. You may return your Tuition Express Parent Authorization Form by email to (theheightscdc@theheights.org), mail to The Heights Child Development Center, 201 W. Renner Rd, Richardson, TX 75080, or our Heights CDC Dropbox outside the Family Entrance doors. If you have further questions, please don't hesitate to ask.

Sincerely,

Holly Lieou

Financial Assistant
hlieou@theheights.org



*Convenient and Safe
On-time Payments*



PARENT FAQs

We are excited to offer automatic payments through Tuition Express. It is no longer necessary for you to write a check for tuition and fees. Your bank or credit card account will be safely and securely debited by Tuition Express. You can be emailed a receipt for each transaction. It's easy to sign-up – just ask us.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?

Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, steal your identity. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?

Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?

If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?

Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize your bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?

Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?

For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.

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) The Heights Child Development 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.

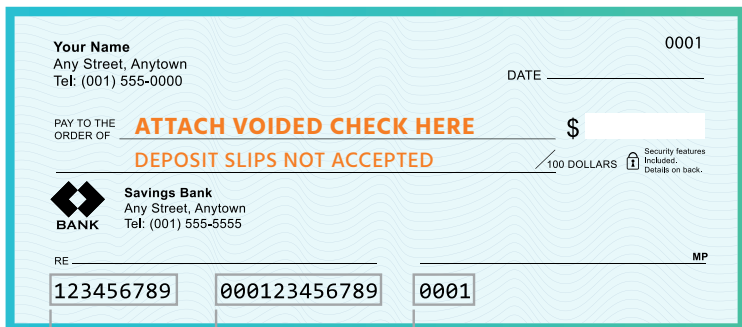
COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date	CVV	
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)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER

ACCOUNT NUMBER

CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

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THE HEIGHTS CHILD DEVELOPMENT CENTER
PERMISSIONS AND AGREEMENTS FORM

CHILD'S NAME: _____

DATE OF BIRTH: _____

PLEASE INITIAL EACH SECTION

Parent Handbook (which includes our discipline and guidance policy):

_____ I acknowledge that I will read The Heights Child Development Center Parent Handbook prior to my child's first day of school and will adhere to its guidelines. (Located online at www.theheightscdc.com under Parent Resources)

Photo/Video Permission and Release

I DO ___ DO NOT ___ give consent for photo/video of my child to be used within the building of The Heights Child Development Center. This will include in print or digital format in the classroom, hallways or to go home with enrolled families for memory purposes. *We do NOT publish photographs of individual children on our website or Facebook page.* In the case where marketing material is needed, we will contact persons on an as-needed basis in order to use photographs on material published for the general public.

Class Directory Permission

I DO ___ DO NOT ___ give consent for my child to be included in The Heights Child Development Center class directory. The following information will be included in the directory: child's name, parents' name, mailing address, phone number, email address.

Directories are only printed by request of a parent and only per each classroom. We never publish a whole-school directory, nor do we provide any information regarding your child to any third-party sources.

Tuition/Fee Agreement

_____ I acknowledge that tuition and other fees are collected monthly through Tuition Express on the 1st of each month. I agree to keep my financial accounts updated to prevent payment declines, and I understand I will be assessed any fees incurred as a result of a decline.

Parent's Signature _____ Date _____

Printed Name of Parent _____



THE HEIGHTS CDC

CHILD DEVELOPMENT CENTER

2023-2024 FAMILY INFORMATION SHEET

The information obtained on this sheet is for the purpose of the teachers in your child's class to better understand your child's family and culture environment, as well as personality and tendencies at home. This information can be very helpful in early childhood education in helping to better understand your child's development and well-being as an individual. All information is maintained in the classroom under confidentiality. Please answer as thoroughly as possible for your child.

Name of Child: _____ DOB: _____

ALLERGIES: _____

Does your child have any of the following: (if yes, please explain)

Does your child have an EPI pen? Y N
Dietary restrictions? _____
Previous serious illness or injuries? _____
Hospitalization during the last 12 months? _____
Any medication prescribed for long term use? _____

How did you find out about The Heights CDC? _____

Previous preschool/MDO attendance? () YES () NO If yes, where: _____

Please Tell Us About Your Child's Family Environment:

Mom's Name: _____ Phone: _____

Employer: _____ Occupation: _____

Dad's Name: _____ Phone: _____

Employer: _____ Occupation: _____

Siblings (name and age): _____

Pets (type and name): _____

Are parents: () Living together () Separated () Divorced Other: _____

If separated or divorced, who has custody of the child? _____

Are there any other adults living in the home? _____

(form continued on back)

Please Tell Us About Your Child's Culture:

Ethnicity: White African-American Hispanic Indian Asian Pacific Islander

Other: _____

What is the primary language spoken at home? _____

What holidays or special traditions do you and your family celebrate? _____

Church attending: _____ No church home: [] (please check here)

Anything else you would like us to know about your child's culture?

Please Tell Us About Your Child's Individual Personality and Behavior/Medical Concerns:

Describe your child's personality: _____

Child's fears or habits we need to be aware of: _____

Describe your child's sleeping habits at naptime, and any information that the teacher could use to assist them in falling asleep: _____

Are there any other issues regarding your child's health and/or behavior of which we should be aware?

Is your child potty trained: () Yes () No Please list any special words used to go to the restroom:

Do you feel there can be a language barrier with the potty training process?

Please list any other special concerns, medical needs, or any additional information that will help us make your child's school year the best it can be:

THE HEIGHTS CHILD DEVELOPMENT CENTER
EMERGENCY MEDICAL INFORMATION AND AUTHORIZATIONS

CHILD'S NAME _____
(Last) (First) (Middle) (Name Called)

DATE OF BIRTH _____ (Month/Day/Year) **ALLERGIES:** _____
(Please complete allergy information sheet on back side of form)

PARENT / GUARDIAN NAME(S) _____

PARENT / GUARDIAN PHONE NUMBER(S) _____

PARENT / GUARDIAN EMAIL ADDRESS(ES) _____

EMERGENCY CONTACTS

Emergency Contacts are someone *other than the parent/guardian* that can be contacted in the case of an emergency that know medical information regarding the child. These persons do not have to be local.

(Minimum of 2 contacts with address and phone number required)

Emergency Contact #1 (OTHER THAN PARENT OR GUARDIAN)

Name: _____ Relationship to child: _____

Address: _____

Phone: _____

Emergency Contact #2 (OTHER THAN PARENT OR GUARDIAN)

Name: _____ Relationship to child: _____

Address: _____

Phone: _____

**A child will only be released from The CDC to his/her mother, father, or other persons authorized by the parents. In the case of marital separation, THBC cannot deny either parent access to a child unless copies of legal documentation stating otherwise are provided.

AUTHORIZED PICK-UP PERSONS: (will not be contacted in emergency – this only gives permission to release your child to this person without having to contact the parent/guardian first – must present PHOTO ID)

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

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 contact the Physician below:

Name of Physician: _____ Address: _____ Phone: _____

And/or the closest emergency medical facility as determined by first responders in the case of a 911 call:

Methodist Richardson Medical Center, 2831 E President George Bush Highway, Richardson, Texas 75080 PH: 469-204-1000

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

Parent's Signature: _____ **Date:** _____

THE HEIGHTS CHILD DEVELOPMENT CENTER
ALLERGY PLAN FOR DIAGNOSED ALLERGIES

CHILD'S NAME _____
(Last) (First) (Middle) (Name Called)

DATE OF BIRTH _____ **ALLERGIES:** _____
(Month/Day/Year)

Please complete the following form for all MEDICALLY DIAGNOSED allergies.

Allergen: _____

Is the allergy to touch or ingestion: _____

Symptoms (please describe any known symptoms to the allergen):

Does your child have an EPI pen? _____ **YES** _____ **NO**

_____ If checked, give Epinephrine immediately for any **LIKELY** ingestion, for **ANY** symptoms.

_____ If checked, give Epinephrine immediately for any **DEFINITE** ingestion, even with no symptoms

Allergen: _____

Is the allergy to touch or ingestion: _____

Symptoms (please describe any known symptoms to the allergen):

Does your child have an EPI pen? _____ **YES** _____ **NO**

_____ If checked, give Epinephrine immediately for any **LIKELY** ingestion, for **ANY** symptoms.

_____ If checked, give Epinephrine immediately for any **DEFINITE** ingestion, even with no symptoms

PARENT/GUARDIAN SIGNATURE

DATE

PHYSICIAN SIGNATURE

DATE

**THE HEIGHTS CHILD DEVELOPMENT CENTER
HEALTH ADMISSION REQUIREMENTS**

Child's Name: _____ Date of Birth: _____ Today's Date: _____

IMMUNIZATION REQUIREMENT: (Check One)

- Attached is a copy of the Immunization Records for the child listed above. I understand that it is my responsibility to bring updated records to the office throughout the year as immunizations are administered.
- I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years.

STATEMENT OF HEALTH REQUIREMENT

One of the following must be presented when your child is admitted to the CDC program or within one week of admission.

1. A PHYSICIAN'S STATEMENT *with signature* is attached.
2. AFFIDAVIT: stating that medical diagnosis and treatment conflict with the tenants 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.*
Parent's Initials: _____
3. PHYSICIANS STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the preschool program. ****PHYSICIAN SIGNATURE REQUIRED**

PHYSICIAN SIGNATURE

DATE

Please Print: Physician Name/Physician Address/ Physician Phone Number

HEARING AND VISION REQUIREMENT
4 & 5 YEAR OLDS ONLY AS OF SEPTEMBER 1ST

(Please check only one option)

- I have attached a copy of the hearing and vision screening results for the above named child.
 Results for the hearing and vision screening are as follows:

VISION: R 20/____ L 20/____ PASS FAIL

HEARING: 1000HZ 2000HZ 4000HZ

R: _____/_____/_____ PASS FAIL

L: _____/_____/_____

PHYSICIAN SIGNATURE

DATE

THE HEIGHTS CHILD DEVELOPMENT CENTER
TOILET TRAINING POLICY (3-, 4- and 5-YEAR-OLDS ONLY)

Children enrolled in The Heights CDC threes and fours program must be toilet trained before attending preschool. Children must be wearing underwear. A child having accidents daily would not be considered toilet trained. Please note that wearing pull ups is NOT considered toilet trained.

Why do children have to be toilet trained before they begin preschool?

- There are strict standards for changing and disposing of wet or soiled diapers/pull ups and our classrooms are not equipped for this.
- When an adult is busy changing a child's soiled clothing, it is taking away from learning time for all students, and it removes our teachers from the direct supervision of and interaction with the rest of the class.

We do understand that even toilet trained children will occasionally have accidents. By definition, "accidents" are unusual incidents and should happen infrequently. In these instances, the teachers will help children to change their clothes, encouraging independence as much as possible.

A toilet trained child is a child who can do the following:

- Communicate to the teachers that he/she needs to go to the restroom before they need to go
- Alert him/herself to stop what he/she is doing, to go and use the bathroom
- Get on/off the toilet by him/herself
- Pull down his/her clothes and get them back up without assistance
- Wipe him/herself after using the toilet without assistance
- Wash and dry hands (*all children must do this*)
- Postpone going if they must wait for someone who is in the bathroom or if we are away from the classroom

We certainly will ask your child many times throughout the day if they need to use the bathroom. A teacher will assist children as needed, but children should be able to complete toileting activities independently. This is an issue which protects all concerned. It is not uncommon for a child who is fully toilet trained to have a setback when he/she is in a new environment. Preschool staff are aware of this and will assist the children when necessary. Please have your child dressed in clothing that he/she can easily manage independently. Please send a complete change of clothes appropriate for the season. These should be left in the child's backpack in case of accidents. Parents will be notified if a child has a toileting accident.

We understand that each child arrives at this milestone differently, therefore we will allow 4 weeks from the first day of school for your child to demonstrate accomplishment of this goal. However, if the situation is not manageable within the classroom environment, we will discuss the issue with the parents and reserve the right to suspend attendance of the child at such time.

A child will not be considered toilet trained for our preschool program if the child continues to consistently have toileting accidents after the first 4 weeks of school. After the first 4 weeks of school, the following policies will be in place for children who have accidents:

- If one or two accidents occur in one week, the parents will be notified with the understanding that the issue needs to be addressed and corrected.
- If three or more accidents occur in one week, the parent will be notified with the understanding that if the issue is not corrected by the end of the second week the child will have to stay home at least one week or longer until he/she is completely toilet trained.
- If multiple accidents occur in one day, the parent will be notified on that day; and if not corrected by day three, the child will have to stay home at least one week or longer until he/she is completely toilet trained.

Please note that this policy is not in place to shame or punish a child or inconvenience primary caregivers. Rather, cleaning accidents in the preschool setting is time consuming, and this time that teachers spend attending to and cleaning accidents is time that they are not spending interacting with children and facilitating the curriculum in a safe manner. This policy is intended to ensure the safety and happiness of children and staff at The Heights Child Development Center.

Thank you for your cooperation and understanding.

PLEASE SIGN AND DATE BELOW INDICATING THAT YOU HAVE RECEIVED & REVIEWED THE TOILET TRAINING POLICY AND RETURN TO THE HEIGHTS CDC.

I HAVE RECEIVED AND REVIEWED THE HEIGHTS CDC TOILET TRAINING POLICY.

CHILD'S NAME: _____ **CHILD'S DOB:** _____

PARENT'S SIGNATURE: _____ **DATE:** _____

**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.

Extremely reactive to the following allergens: _____








THEREFORE:

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

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 SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, 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

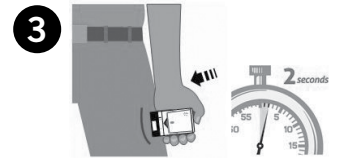
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

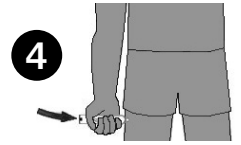
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



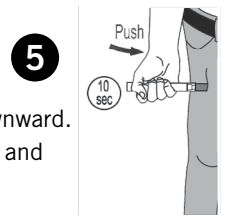
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. 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.
3. 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).
4. 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 ADRENALICK®), 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.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____