

# Blossom Valley Academy

1252 College Pkwy, Lewisville, Texas -75077

(972)-436-3613

email: blossomvalleyacademy@gmail.com

## Student Application and Enrollment Form

( PLEASE USE CAPITAL LETTERS TO COMPLETE THE FORM )

Enrollment Date: \_\_\_\_\_ Home Phone number: \_\_\_\_\_

Child name#1: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child name#2: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child name#3: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Home Address:

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Days of care (please circle all that apply)      Monday      Tuesday      Wednesday      Thursday      Friday

Mother's/Guardian name: \_\_\_\_\_

Mother's Drivers License No. \_\_\_\_\_ Issuing State: \_\_\_\_\_ SSN# \_\_\_\_\_

Mother's Email: \_\_\_\_\_ Mobile#: \_\_\_\_\_

Father's/Guardian name: \_\_\_\_\_

Father's Drivers License No. \_\_\_\_\_ Issuing State: \_\_\_\_\_ SSN. # \_\_\_\_\_

Father's Email: \_\_\_\_\_ Mobile#: \_\_\_\_\_

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If parents are divorced, who has legal custody? \_\_\_\_\_

(please provide court documents)

If a non-Custodial parent allowed to pick up the child (full name)? \_\_\_\_\_

DL# \_\_\_\_\_ Issuing state: \_\_\_\_\_ Mobile#: \_\_\_\_\_

## Transportation Authorization (Provided by Staff)

## Permission & Consent for Transportation

To/ From Field trip(s)

I GIVE permission

I DO NOT give permission

To/From Public Schools

I GIVE permission

I DO NOT give permission

Name of Public School: \_\_\_\_\_ (if applicable)

Public School's Phone No. \_\_\_\_\_ (if applicable)

## Authorized to pick up Child (other than parent/guardian):

Name#1: \_\_\_\_\_ Mobile #: \_\_\_\_\_ DL# \_\_\_\_\_

Name#2: \_\_\_\_\_ Mobile #: \_\_\_\_\_ DL# \_\_\_\_\_

## Emergency contact (other than parent/guardian): (if different from above otherwise write "same")

Name#1: \_\_\_\_\_ Mobile #: \_\_\_\_\_ DL# \_\_\_\_\_

Name#2: \_\_\_\_\_ Mobile #: \_\_\_\_\_ DL# \_\_\_\_\_

Briefly describe about your child that may help the teachers in the classroom (if any):

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**Special needs/Allergies documentation (if any).** Please bring Allergy or Special needs form signed by Doctor.

<p>Child(ren) name[s] (complete this section only if there are special needs or allergies to list. ) (<u>Allergy form to be signed by Doctor is required</u>)</p>	<p>List any special problems that your child may have such as an existing illness, previous serious illness, allergies, injuries occurred in the past 12 months, medications used/are using, etc. Please also state any other information the staff should be aware of (use a separate sheet if needed to explain).</p>
<p>Child name#1:</p>	
<p>Child name#2:</p>	
<p>Child name#3:</p>	

**Fees, Tuition, Agreements:**

<p><input type="checkbox"/> I agree to pay the WEEKLY tuition fee of \$ _____ by TUESDAY of each week without fail.</p>
<p><input type="checkbox"/> I agree to pay the \$5.00 fine for every 15 minutes that my child is left at school after 6:30pm.</p>
<p><input type="checkbox"/> I have been given a tour of preschool, parent handbook with operational policies of the preschool / daycare which I agreed to.</p>

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## PERMISSION TO PHOTOGRAPH YOUR CHILD(REN) LISTED ON THIS FORM:

I hereby give permission for *Blossom Valley Academy* to photograph, video record and use picture(s) & footage(s) of my child/children and/or examples of their school work.

### **Following terms are applicable on the videos/photographs taken at Blossom Valley Academy:**

- 1) *Blossom Valley Academy* undertakes to use the photograph(s) only in printed promotional materials, parent email(s), on-line publications, any social media and on the Blossom Valley Academy family website.
- 2) *Blossom Valley Academy* undertakes **not** to disclose the name or provide any details of any child in any way to any person or entity.
- 3) *Blossom Valley Academy* undertakes **not** to make any photos or video tapes of any child available to any person or entity.
- 4) *Blossom Valley Academy* undertakes **not** to sell any child's photographs, video tapes or examples of school work for any direct commercial gain.
- 5) *Blossom Valley Academy* and the parent/guardian named below agree that there shall be no remuneration for the use of any child's photographs, video or school work.

**I understand that this completed application must be on file, along with the following BEFORE attendance will be allowed:**

Completed Health/Medical Form	Signed Child Care Agreement Form	Latest shot record
Registration fee	Completed Emergency Medical Info.	One week of tuition

**Print name of Guardian/Parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Guardian/Parent:** \_\_\_\_\_

**THANK YOU VERY MUCH FOR TRUSTING US WITH YOUR CHILD'S DEVELOPMENT.**

COVID-19 PUBLIC HEALTH EMERGENCY  
SPECIAL PROGRAM ATTENDANCE  
ACKNOWLEDGMENT AND DISCLOSURE

Dear Parent / Guardian,

Please read and initial each statement and sign on the back. Please understand this is a legal document.

1. \_\_\_\_\_ I (We) understand that during this COVID-19 Public Health Emergency I (We) will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I (We) understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.
2. \_\_\_\_\_ I (We) understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area I (We) MUST wash my hands before entering, remove my shoes and wear a mask. While in the facility I (We) must practice social distancing and remain 6ft from all other people, except for my own child(ren).
3. \_\_\_\_\_ I (We) understand that to enter upon the facility premises my child(ren) must be free from COVID-19 symptoms as described on CDC's website <https://www.cdc.gov/coronavirus>. If, during the day, any of the following symptoms appear my child(ren) will be separated from the rest of the people in the center. I (We) or my authorized contact on file will be contacted, and my child(ren) MUST be pick-ed up from the facility within 30 minutes of being notified. Your child(ren) will need to be symptom free without any medications for 72 hours before returning to the facility.
4. \_\_\_\_\_ I (We) understand that my child(ren) will be required to wash their hands & follow other preventative measure as described on CDC's website <https://www.cdc.gov/coronavirus>. Furthermore, I (We) will NOT send already sick person to pickup or drop off my child(ren).
5. \_\_\_\_\_ I (We) will immediately notify Blossom Valley Academy management if I (We) become aware of any person with whom my child(ren), my family members or other individuals have had contact exhibits any of the symptoms listed in symptoms as described on CDC website <https://www.cdc.gov/coronavirus>, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19.
6. \_\_\_\_\_ I (We) understand that while present in the facility each day my child(ren) will be in contact with child(ren)ren, families and other employees who are also at risk of community exposure. I (We) understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I (We) understand that I (We) play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

7. \_\_\_\_ I (We) release BLOSSOM VALLEY ACADEMY management & parent company from any and all claims and liabilities of whatsoever nature, individually and collectively arising from my child(ren) attending the facility.

I (We), \_\_\_\_\_ certify that I (We) have read, understand and agree to comply with the provisions listed herein. I (We) acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by BLOSSOM VALLEY ACADEMY management reserves the right to take appropriate disciplinary action including unenroll my child(ren) from the center.

Child(ren) Name#1: \_\_\_\_\_ DOB: \_\_\_\_\_

Child(ren) Name#2 (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_

Child(ren) Name#3 (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

Parent / Guardian Name: \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Management Team Witness

\_\_\_\_\_  
Date

**BLOSSOM VALLEY ACADEMY**  
1252 COLLEGE PARKWAY, LEWISVILLE, TX - 75077  
PH# 972-436-3613  
EMAIL: [BLOSSOMVALLEYACADEMY@GMAIL.COM](mailto:BLOSSOMVALLEYACADEMY@GMAIL.COM)  
(Hereby known as the Child Care Facility or Facility)  
**INDEMNITY AGREEMENT**

Please print full names of child(ren) enrolled. Please review in entirety of this document and sign

**Child Name#1:**

**Child Name#2 (if applicable):**

**Child Name#3 (if applicable):**

I (we) have read and fully understand all sections of the Child Care Agreement as presented to me by the staff of the above-named Child-Care Facility. I (we) agree to abide by this Indemnity Agreement and to discuss any problems or questions I (we) might have regarding the care of my child while at this Child Care Facility.

I (we) **release** the Child Care Facility from any and all claims and liabilities of whatsoever nature, individually and collectively, arising from accidents that might occur while my child(ren) is on the premises of the Facility, on field trips, or attending any school sponsored function; or as a result of conditions or circumstances beyond its control.

I (we) **understand** it is against the policy of the child Care Facility for any of its staff to baby-sit for students who are enrolled at the Child Care Facility, even when away from the Facility on a private basis. Should any staff member choose to baby-sit for a student(s) enrolled at the Facility against the Facility's policy, the Facility and its owners disclaim any responsibility or liability for any injury, improper conduct or any other matter that might arise while such staff member is baby-sitting for a student(s) of the Child Care Facility off the premises of the Facility.

By signing this form, I (we) acknowledge that I am (we are) aware of the Child Care Facility's policy against any staff member of the Facility baby-sitting for any student(s) enrolled at the Facility. Should I (we) choose to hire such a staff member to baby-sit for me on a private basis, the Child Care Facility will **not be liable or responsible** for any issues that might arise/happen while such member is baby-sitter or caregiver.

Acknowledgement(s):

Parent/ Guardian Signature: \_\_\_\_\_

Parent/ Guardian Name (Print):

Parent/ Guardian Signature: \_\_\_\_\_

Parent/ Guardian Name (Print):

Date of enrollment:

Staff signature:

## Parents/Guardians:

As a Texas Rising Star provider, we must abide by certain nutrition policies and procedures. Please be assured that during meal times, **we practice the following policies and procedures:**

- A. Liquids and foods hotter than 110 degrees Fahrenheit are kept out of reach of the children.
- B. Staff are educated on food allergies and they take precautions to ensure children are protected.
- C. On days that providers serve meals, prepared food that is brought into the program to be shared among children is commercially prepared OR prepared in a kitchen that is inspected by local health officials.
- D. Health snacks (as listed by the Texas Department of Agriculture) are available for school- aged children as students arrive.
- E. Staff do not reward good behavior or clean plate with foods of any kind.
- F. On days that providers serve meals, milk, fresh fruits, and vegetable are available for children who bring lunches from home.

In regard to **food brought in from home**, we practice the following policies and procedures:

- A. We ensure that safety of food brought from home, include refrigeration or other means to maintain appropriate temperatures.
- B. We have policies in place outlining strategies to educate children and their parents on nutrition.
- C. We provide parents with information about foods may cause allergic reaction.
- D. We provide sample menus of healthful lunches for parents whose children bring food from home. Parents are encouraged to provide meals with adequate nutritional value.

For sample menus, please visit the following website:

<http://www.choosemyplate.gov/healthy-eating-tips/sample-menu-recipes.html>

For information about foods that may cause an allergic reaction, please visit the following website:

[http://kidshealth.org/parent/growth/feeding/food\\_allergies.html](http://kidshealth.org/parent/growth/feeding/food_allergies.html)



Please contact the office for additional information and details on nutritional food programs.

Acknowledge Receipt of this information:

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

**BLOSSOM VALLEY ACADEMY**  
**Ph# 972-436-3613**  
**Physician Order/Severe Allergy Action Plan**



Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Grade: \_\_\_\_\_

**ALLERGIC TO:** \_\_\_\_\_  
 Asthmatic Yes\*  No  \*Higher risk for severe reaction

**STEP 1: TREATMENT (This section to be completed by authorizing physician)**

Symptoms:

Give Checked Medications

- If exposure to allergen (e.g., sting, food ingested), but has no symptoms  Epinephrine  Antihistamine

**MILD SYMPTOMS**

- Mouth Itchy runny nose, sneezing  Epinephrine  Antihistamine
- Skin A few hives, mild itch  Epinephrine  Antihistamine
- Gut Mild nausea/discomfort  Epinephrine  Antihistamine

**SEVERE SYMPTOMS - Potentially Life-Threatening**

- Throat Tightening of throat, hoarseness, hacking cough
- Lung Shortness of breath, repetitive coughing, wheezing
- Heart Weak pulse, faint, pale, blue, dizzy
- Gut Repetitive vomiting, severe diarrhea
- Skin Many hives over body, widespread redness
- Other \_\_\_\_\_



**INJECT  
EPINEPHRINE  
IMMEDIATELY**

The severity of symptoms can quickly change. When both Epinephrine and Antihistamine are checked, **Epinephrine will be given first.** Antihistamine or other med given only if student alert and able to swallow.

**DOSAGE**

**Epinephrine:** Inject intramuscularly (**check one**)  Epinephrine 0.15mg  Epinephrine 0.3 mg

**Antihistamine:** give \_\_\_\_\_ **Other:** give \_\_\_\_\_  
 Medication/dose/route Medication/dose/route

**Physician's Signature** \_\_\_\_\_ **Start Date:** \_\_\_\_\_ **\*End Date:** \_\_\_\_\_  
 (Required)

Physician's name (printed) \_\_\_\_\_ Phone \_\_\_\_\_ Fax number \_\_\_\_\_

**This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine:**

Physician's Signature and Date	Parent Signature and Date	Student's Signature and Date
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FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

\_\_\_\_\_  
 SHA Signature and Date                      Name of PHN Contacted by Phone & Date                      PHN Signature and Date  
 Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only.                      Revised 6/15

**TURN FORM OVER**

*Students with conditions that may substantially impact school functioning (including medical or psychological conditions) may be eligible for accommodations under federal laws, specifically Section 504 of the Rehabilitation Act. Students or parents who are concerned that a diagnosed condition may interfere with the student's ability to access or participate in school activities should discuss their concerns with a school administrator.*

## **STEP 2: EMERGENCY CALLS (To be completed by parent/guardian)**

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call **Parent/Guardian** or Emergency contact(s):

	<b>Name/Relationship</b>	<b>Phone Number(s)</b>
a.	_____	1. _____ 2. _____
b.	_____	1. _____ 2. _____
c.	_____	1. _____ 2. _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

*I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.*

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*Order form good for one school year including Summer School.

**Medication expiration dates:** \_\_\_\_\_

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

\_\_\_\_\_  
SHA Signature and Date  
Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only.

\_\_\_\_\_  
Name of PHN Contacted by Phone & Date  
Revised 6/15

\_\_\_\_\_  
PHN Signature and Date

# ACH Payment Authorization

You authorize regularly scheduled charges to your Bank Account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Bank Account Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I \_\_\_\_\_ authorize **Nimble Holdings Inc DBA Blossom Valley Academy** to charge my Bank Account below for \$ \_\_\_\_\_ beginning on \_\_\_\_\_ (Date) every week / month.

Services Rendered: Preschool / Daycare / After-School / Pre-School or any other educational services (circle all that apply)

Name(s) of child(ren) payment for:

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## Billing Details:

Billing Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Complete your bank details that appear on your check on the second page of this document.

## Example check showing the Account number and Routing Number.

The image shows a check from Central Valley Community Bank. The check is addressed to JOHN DOE at 1234 MAIN ST, FRESNO, CA 93711. The amount is 1234 DOLLARS. The check number is 12345678900000. The routing number is 121137726. The account number is 12345678900000. The check is dated 12/31/2020. The bank logo is Central Valley Community Bank. The check number is 12345678900000. The routing number is 121137726. The account number is 12345678900000. The check is dated 12/31/2020. The bank logo is Central Valley Community Bank.

JOHN DOE  
1234 MAIN ST  
FRESNO, CA 93711

DATE \_\_\_\_\_ 1234

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_  
DOLLARS

Central Valley Community Bank

MEMO \_\_\_\_\_ MP

⑆ 121137726 ⑆ 12345678900000 ⑆

Routing No. Check No. Account No.

## Your Bank (ACH) Information:

- Checking Account  - Savings Account

Name of account holder as appears on check: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Routing Number: \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

**Account Holder's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Effective July 1<sup>st</sup> 2020

**BLOSSOM VALLEY ACADEMY**

1252 College Parkway, Lewisville Texas 75077

[blossomvalleyacademy@gmail.com](mailto:blossomvalleyacademy@gmail.com)

[www.blossomvalleyacademy-tx.com/](http://www.blossomvalleyacademy-tx.com/)

**(972) 436-361**

FEES SCHEDULE

The following rates are the current fees for Blossom Valley Academy.

Annual Registrations fees

Preschool- Kindergarten: \$80

Public Schoolers: 1st through 5<sup>th</sup> Grades: \$50

**REGULAR TUITION FEES (prices include Breakfast, Lunch & Snack)**

<b>Full-Time Rates:</b>	<b>Weekly Basis</b>	<b>Monthly Basis</b>
Infants (6 weeks-17 months)	\$225	\$900.00
Toddlers (18-36 months or until potty trained)	\$200.00	\$800.00
Full-Time Pre-School (36 months and above and potty trained)	\$175.00	\$700.00
Before AND After School	\$110.00	\$440.00
After-School only	\$85.00	\$340.00
Summer Full Day Program	\$150	\$600

<b>Part-Time Rates</b>	<b>2 Days a week Weekly pay</b>	<b>3 Days Weekly pay</b>
Infants (6 weeks -17) months	\$150.00	\$175.00
Toddlers (18-36 months or until potty trained)	\$110.00	\$140.00
Pre-Schoolers	\$100.00	\$135.00

Extra day(s) .... There will be an extra charge of \$15.00 per day for the public-school children who are at Blossom Valley for a full day (i.e. Thanksgiving Week, Christmas Break, Spring Break.) breakfast, lunch, and snack will be provided.

Please note that COVID timings are: 7:30AM – 5:30PM.

Payment may be made on either a weekly or monthly basis. You must choose a payment schedule when you enroll and pay according to that schedule,

ALL TUITION IS DUE AND PAYABLE WHETHER YOUR CHILD IS/ IS NOT IN SCHOOL. All tuition is due and payable in advance. If you are paying on a weekly basis, your tuition is due by **Monday morning** of each week. A **\$20.00 late fee** will be added to your account if the tuition has not been paid by 6:30 p.m. on Tuesday. If you are paying on a monthly basis, your tuition is due by the **first day of each month**. A **\$20.00 late fee** will be added to your account if it has not been paid by 6:30 p.m. on the 5th day of the month.

There is a \$35.00 service charge for all returned checks.

There will be NO DEDUCTIONS FOR ABSENCES, ILLNESS OR HOLIDAYS (as listed in the Child Care Agreement), and NO SUBSTITUTE DAYS FOR PART TIME STUDENTS.

The **school closes at 6:30 p.m.** If your child(ren) has not been picked up by 6:30 pm, a teacher will stay with your child(ren), and a **fee of \$5.00 for every 15 minutes**, or portion thereof, must be paid to the teacher for staying with your child(ren)

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(Signature of the Parent / Guardian)

Date:

## PARENT EDUCATION

The provider conducts an orientation to the family at enrollment. A signed and dated copy of the content of the orientation is kept in the child's file

The orientation includes:

- Tour of the facility
- Introduction to the teaching staff
- Parent visit with the classroom teacher
- Overview of parent handbook
- Policy for arrival & late arrival
- Opportunity for an extended visit in the classroom by both parent and child for a while to be comfortable in the environment
- An explanation of Texas Rising Star Quality Certification is provided
- Encourage parents to inform the center/provider of any elements related to their CCS enrollment that the provider may be of assistance
- An overview of family support resources and activities in the community
- Child development and developmental milestones provided

### Expectations of the family:

- Parents are informed of the significance of consistent arrival time:
  - Before educational portion of school readiness program begins.
  - Impact of disrupting learning of other children.
  - Importance of consistent routines in preparing children for the transition to kindergarten.
- Statement about limiting technology use can site to improve communication between staff, children, and families (e.g., refrain from cell phone use). In order to facilitate better communication between the parent(s) and teacher and the parent and child it's best if parents are not distracted by use of electronic devices while at the center/home.
- Statement reflecting the role ad influence of families.
- Consent for photo release
- Indemnity agreement for Blossom Valley Academy

### **Receipt of Acknowledgement:**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date \_\_\_\_\_.