

Dear New Parents,

Thank you for enrolling your child at Open Arms Child Care Center. I'd like to take a minute to guide you through some of this paperwork.

PHYSICAL & IMMUNIZATIONS

Physicals and Immunizations must be received with your child's enrollment paperwork or within 30 days of enrollment. If a physical is not received within this time, your child will not be eligible to remain at Open Arms. Your medical paperwork must include a physical (updated annually), a Lead Test (repeated annually until 48 months), a varicella immunization at 12 months, and required immunizations listed on the attached sheets.

ENROLLMENT PAPERWORK

This paperwork must be fully completed and returned at least one week prior to your child starting at Open Arms. It is important for the teachers to have this information to prepare for your child.

PARENT HANDBOOK

Please read this handbook completely. It contains information on all Open Arms Policies including our Health Care Policy, Tuition Policy, and Withdrawal Policy. You will be asked to sign an acknowledgment form, included in your enrollment paperwork, stating that you are aware of Open Arms Policies.

WELCOME PACKET

This packet includes information specific to the program your child will be entering.

TUITION

Your regular monthly tuition amount will be given to you upon enrollment. Tuition is payable through Simply Giving® by the 25th of the month **prior** to services. If you begin your enrollment part way through the month, we will give you a prorated amount for that month. Tuition must be paid prior to your child starting at Open Arms.

We require a written four week notification of withdrawal for any reason.

Please feel free to call our office at 413-569-5151, extension 16, if you have any questions.

Thank You,

Kathie Couture
Director

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: M F

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

| Vaccine | | Date/Vaccine Type | Vaccine | | Date/Vaccine Type |
|---|---|-------------------|--|---|-------------------|
| Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB) | 1 | | Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series) | 1 | |
| | 2 | | | 2 | |
| | 3 | | | 3 | |
| | 4 | | Measles, Mumps, Rubella (MMR, MMRV) | 1 | |
| 1 | | 2 | | | |
| Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap) | 2 | | Varicella (Var, MMRV) | 1 | |
| | 3 | | | 2 | |
| | 4 | | Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4) | 1 | |
| | 5 | | | 2 | |
| | 6 | | Influenza Inactivated (Intramuscular) or Live (Intranasal) | 1 | |
| | 7 | | | 2 | |
| 1 | | 3 | | | |
| 2 | | 4 | | | |
| Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib) | 3 | | 5 | | |
| | 4 | | 6 | | |
| | 1 | | Pneumococcal Polysaccharide (PPV23) | 1 | |
| | 2 | | | 2 | |
| Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib) | 3 | | Hepatitis A (HepA, HepA-HepB) | 1 | |
| | 4 | | | 2 | |
| | 5 | | Human Papillomavirus (HPV) | 1 | |
| 1 | | 2 | | | |
| 2 | | 3 | | | |
| Pneumococcal Conjugate (PCV7) | 3 | | Other: | | |
| | 4 | | | | |
| | | | | | |
| | | | | | |

| Serologic Proof of Immunity | | Check One | |
|-----------------------------|--------------|-----------|----------|
| Test (if done) | Date of Test | Positive | Negative |
| Measles | / / | | |
| Mumps | / / | | |
| Rubella | / / | | |
| Varicella* | / / | | |
| Hepatitis B | / / | | |

* Must also check Chickenpox History box.

| Chickenpox History |
|---|
| <input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> physician interpretation of parent/guardian description of chickenpox physical diagnosis of chickenpox, or serologic proof of immunity |

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print): _____

Date: / /

Signature: _____

Facility name: _____

ACKNOWLEDGEMENT FORM

Child's Name _____

I, _____ (Parent's/Guardian's Name)
have read and agree to the policies outlined by Open Arms Child Care Center regarding
the following:

- ◇ Child Guidance Policy
- ◇ Procedures for Emergency and Illness
- ◇ Plan for Ill Children
- ◇ Plan for Administration of Medication
- ◇ Toileting and Diapering Policy
- ◇ Toddler Biting Policy
- ◇ Referral Services and Termination Policy
- ◇ Field Trip Policy
- ◇ I give permission for _____
(Child's name)
to take walks on Open Arms/Christ Lutheran Church property.
- ◇ Tuition and Withdrawal Policies

(Parent's/Guardian's Signature)

(Date)

Valid for one year from date of signature.

Open Arms Child Care Center Allergy Form

Let us know if your child has any allergies or special medical conditions which we need to be aware of. In case of emergencies it is important for our teachers to have this information.

Write any important information on this sheet and return it with your enrollment paperwork. Please let us know if any of this information is confidential.

Child's Name: _____

Allergies: _____

Medical Condition: _____

Special Instructions: _____

**OPEN ARMS CHILD CARE CENTER
CHILD RELEASE POLICY**

To ensure children's safety, Open Arms will release a child only to the people listed below. By signing this form, I understand that Open Arms will not release my child to any other person unless I notify the center in advance, following the guidelines:

- If the person (spouse, relative, friend) picking up my child is listed on this form, I must notify the center verbally.
- If the person picking up my child is NOT listed on this form, I must notify the center in writing.
- Photograph identification will be required of any person picking up my child.

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

1. Name: _____ Relationship: _____

Address: _____ Day Phone: _____

City/Town & Zip: _____ Evening Phone: _____

2. Name: _____ Relationship: _____

Address: _____ Day Phone: _____

City/Town & Zip: _____ Evening Phone: _____

3. Name: _____ Relationship: _____

Address: _____ Day Phone: _____

City/Town & Zip: _____ Evening Phone: _____

4. Name: _____ Relationship: _____

Address: _____ Day Phone: _____

City/Town & Zip: _____ Evening Phone: _____

Parent/Guardian's Signature: _____ Date: _____

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME _____ **DATE OF BIRTH** _____

*Note: Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail _____

Favorite foods: _____

Foods refused: _____

* Is your child fed held in lap? _____ High chair? _____

* Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used?

*Is there a frequent occurrence of diaper rash?

*Do you use: oil _____ powder _____ lotion _____ other _____

*Are bowel movements regular? _____ how many per day? _____

*Is there a problem with diarrhea? _____ constipation? _____

*Has toilet training been attempted? _____

*Please describe any particular procedure to be used for your child at the center

What is used at home? pottychair? _____ special child seat? _____ regular seat? _____

How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____

Does your child become tired or nap during the day (include when and how long)? _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) _____

SOCIAL RELATIONSHIPS

How would you describe your child: _____

Previous experience with other children/day care: _____

Reaction to strangers: _____ Able to play alone: _____

Favorite toys and activities: _____

Fears (the dark, animals, etc): _____

How do you comfort your child: _____

What is the method of behavior management/discipline at home: _____

What would you like your child to gain from this childcare experience? _____

DAILY SCHEDULE: Please describe your child's schedule on a typical day.

*For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

Is there anything else we should know about your child? _____

Parent/Guardian Signature: _____ Date: _____

OPEN ARMS
CHILD'S FACE SHEET/ENROLLMENT FORM

Program _____ Group Day Care _____ School Age Care _____

Child's Name _____ Eye Color _____ Skin Color _____

Home Address _____ Hair Color _____ Height _____

Telephone _____ Sex _____ Weight _____

Date of Admission _____ Age at Admission _____

Date of Birth _____ Primary Language _____

Identifying Marks _____

Allergies/ Special Diets _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name _____

Parent/Guardian Name _____

Relationship to Child _____

Relationship to Child _____

Home Address _____

Home Address _____

Home Telephone # _____

Home Telephone # _____

Business Name _____

Business Name _____

Business Address _____

Business Address _____

Business # _____

Business # _____

Hours at Work _____

Hours at Work _____

ADDITIONAL INFORMATION:

Child's Physician/Clinic _____
name address phone

Chronic Health Conditions _____

Special Limitations or Concerns _____

Parent/Guardian Signature

Date

SCHOOL AGE ONLY

Current School _____ School Address _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school.
Parent/Guardian initials: _____

**OPEN ARMS
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM**

Child's Name _____ Date of Birth _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

EMERGENCY CONTACTS (in order to be contacted)

Name: _____ Address: _____

Relationship to Child: _____ Phone #: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Address: _____

Relationship to Child: _____ Phone #: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Address: _____

Relationship to Child: _____ Phone #: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage: _____ Policy# _____

Parent(s) Name _____ Phone(work) _____
Phone(home) _____

Parent(s) Name _____ Phone(work) _____
Phone(home) _____

Parent/Guardian Signature _____
Date

Medication Consent Form
102 CMR 7.05(2)(c)

Name of child: _____

Name of medication: _____

Prescription: _____ Non-Prescription: _____

Dosage: _____

Date(s) medication to be given: _____

Time(s) medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Name and phone number of prescribing physician:

Directions for storage: _____

I, _____, (parent or guardian) give permission to authorized staff member(s) to administer medication to my child as indicated above.

Parent/Guardian Signature

Date

Doctor's Signature: _____
(for non-prescription medication)

OPEN ARMS CHILD CARE CENTER PARENT CONTRACT

Please check the days your child will attend:

| | | | | | | |
|-----------|-------|------|-------|----|-------|--------------------------|
| Monday | _____ | From | _____ | To | _____ | Child's Name: _____ |
| Tuesday | _____ | From | _____ | To | _____ | Effective date: _____ |
| Wednesday | _____ | From | _____ | To | _____ | Reason for change: _____ |
| Thursday | _____ | From | _____ | To | _____ | _____ |
| Friday | _____ | From | _____ | To | _____ | |

A tuition fee of \$ _____ is due on the 25th of each month and payable through the Simply Giving Program® with no deduction for any absences, holidays, or snow days.

Tuition not paid in full by the last working day of the month will be assessed a \$5.00 per day charge for the first 10 days. Suspension/Termination may result after that time period if a payment plan is not agreed upon and adhered to.

I, _____ (Parent/Guardian Sponsor Name) and/or
_____ (Parent/Guardian Co-Sponsor Name) agree to the contracted hours and tuition amount. If these hours change in any way, I will notify Open Arms immediately so that they may arrange for proper staffing. If we go beyond our normal contract hours, we understand that the appropriate fees will be charged to my account. Tuition rates will be adjusted accordingly for changes in contract. Tuition may be adjusted annually with a 30 day notice.

We understand that if it becomes necessary for us to withdraw our child from the Center, a one month notice must be submitted in writing to the Director, and we are responsible for paying tuition for the one month notice.

Signature of both parents is required.

Parent/Guardian Sponsor Signature

Date

Parent/Guardian Co-Sponsor Signature

Date

Registration Form
Open Arms Child Care Center
PO Box 1107
568 College Highway
Southwick, MA 01077
413-569-5151
Hours of Operation 7:00-6:00

Welcome to Open Arms Child Care Center. You have chosen a state of the art facility, which will provide the highest quality early care and education, as well as an introduction to God and Christian values.

To register your child, please return this completed form to Open Arms with a non-refundable registration fee of \$50.00 for one child, \$15.00 for each additional child. When your registration form and fee are received, the Center Director/Center Administrator will contact you regarding the enrollment process.

We look forward to providing a unique learning experience for your child and developing a partnership between home and school.

Child's Name: _____ Date of Birth: _____

Parent/Guardian:

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Parent/Guardian location during childcare:

Name: _____ Name: _____

Name of Employer: _____ Name of Employer: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Instructions: _____ Instructions: _____

Schedules (Please check one):

Mon-Fri (8-9 hours) _____ Mon-Wed-Fri (8-9 hours) _____ Tue-Thu (8-9 hours) _____

Mon-Fri (4 hours) _____ Mon-Wed-Fri (4 hours) _____ Tue-Thu (4 hours) _____

Before School only _____ Before & After School _____ After School Only _____

Arrival/Departure times: _____

What date would you like enrollment to begin? _____

How did you hear about Open Arms Child Care Center? _____

Parent/Guardian Signature: _____ Date: _____

Open Arms Child Care Center Permission for Topical Creams and Ointments

I give permission for the staff of Open Arms Child Care to apply non-prescription creams and ointments to _____ . I understand that these creams can't
(child's name)
be applied to a rash which is open or bleeding without a note from my child's pediatrician.

Parent's Signature

Date

*This form will expire one year from date signed.

All creams and ointments must be supplied by the parent and labeled with the child's name.

Ointments and creams may include:

Desitin, Balmex, other diaper creams, hydrocortisone cream, petroleum jelly, other over the counter creams.

Massachusetts School Immunization Requirements 2008*

| | Child Care/Preschool ¹ | Kindergarten | Grades 1-6 | Grades 7-12 | College ² |
|--------------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|--|---|
| Hepatitis B³ | 3 doses | 3 doses | 3 doses | 3 doses | 3 doses for all health science students and all full-time undergraduate and graduate students |
| DTaP/DTP/DT/Td⁴ | ≥4 doses DTaP/DTP | 5 doses DTaP/DTP | ≥4 doses DTaP/DTP or ≥3 doses Td | 4 doses DTaP/DTP or ≥3 doses Td; plus 1 Td booster | 1 Td booster within last 10 years |
| Polio⁵ | ≥3 doses | 4 doses | ≥3 doses | ≥3 doses | N/A |
| Hib⁶ | 1 to 4 doses ⁶ | N/A | N/A | N/A | N/A |
| MMR⁷ | 1 dose | 2 doses measles, 1 mumps, 1 rubella | 2 doses measles, 1 mumps, 1 rubella | 2 doses measles, 1 mumps, 1 rubella | 2 doses measles, 1 mumps, 1 rubella |
| Varicella⁸ | 1 dose | 1 dose | 1 dose | <13 years - 1 dose ≥13 years - 2 doses | N/A |
| Meningococcal^{9, 10} | N/A | N/A | N/A (see footnote ¹⁰) | 1 dose for all new full-time residential students (see footnote ⁹) | 1 dose for all new full-time residential students (see footnote ⁹) |

*These requirements also apply to **all** new “enterers.” **N/A** means there is no vaccine requirement for the grades indicated.

1Child Care/Preschool: Minimum requirements by 24 months; younger children should be immunized according to schedule for their age.

2College: Requirements apply to: 1) all full-time undergraduate and graduate students; 2) all full-time and part-time health science students; and 3) any full-time or part-time student attending any postsecondary institution while on a student or other visa, including foreign students attending or visiting classes as part of a formal academic visitation or exchange program.

3Hepatitis B: 3 doses are required for child care attendance and entry into preschool, kindergarten-12th grade, and college (full-time undergraduate and graduate students, as well as all full- and part-time undergraduate and graduate health science students). Laboratory proof of immunity is acceptable.

4DTaP/DTP/DT/Td: ≥4 doses are required for child care attendance and entry into preschool. 5 doses of DTaP/DTP are required for school entry unless the fourth dose is given on or after the 4th birthday. DT is only acceptable when accompanied by a letter stating a medical contraindication to DTaP/DTP. A **single** booster dose of Td is required for all students entering grades 7-12 (Tdap is also acceptable). Please note: Td is not required if it has been <5 years since their last dose of DTaP/DTP/DT.

5Polio: ≥3 doses are required for child care attendance and entry into preschool. 4 doses are required for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which case only 3 doses are needed. However, if the sequential or a mixed IPV/OPV schedule was used, 4 doses are always required to complete the primary series.

6Hib: Hib vaccine is required for child care attendance and preschool entry. The number of primary doses is determined by vaccine product and age the series begins.

7MMR: 1 dose is required for child care attendance and entry into preschool. A second dose of measles vaccine, given at least 4 weeks after the first, is required for entry to all grades K-12, and college. Laboratory proof of immunity is acceptable.

8Varicella: 1 dose is required for child care attendance and for all students at entry to preschool and kindergarten-12th grade, unless they have a physician-certified reliable history of chickenpox. If the child is ≥13 years of age at first vaccination, 2 doses are required.

A reliable history of chickenpox is defined as: 1) physician interpretation of parent/guardian description of chickenpox; 2) physician diagnosis of chickenpox; or 3) laboratory proof of immunity.

9Meningococcal: Meningococcal immunization is required for: 1) newly enrolled full-time students attending a secondary school with grades 9-12 (in the case of ungraded classrooms, those with students 13 years or older) who will be **living in a dormitory or comparable congregate living arrangement** licensed or approved by the secondary school; and 2) newly enrolled full-time undergraduate and graduate students in a degree granting program at a postsecondary institution (e.g., colleges) who will be **living in a dormitory or comparable congregate living arrangement** licensed or approved by the postsecondary institution. These institutions are also required to supply all newly enrolled full-time students (or their parent/legal guardian) who will be **living in a dormitory or comparable congregate living arrangement** with the MDPH developed Meningococcal Information and Waiver Form.

All affected students must: 1) receive information about meningococcal disease and vaccine; and 2) provide documentation of receipt of 1 dose of meningococcal polysaccharide vaccine within the last 5 years (or a dose of meningococcal conjugate vaccine at anytime in the past). As an alternative, affected students or their parent/legal guardian may sign the Meningococcal Information and Waiver Form developed by MDPH to indicate that they read and understood the required information related to the risks of meningococcal disease and: a) elected to decline the vaccine; or b) could not obtain meningococcal vaccine due to a shortage, but wish to receive it. These requirements apply to **all newly enrolled full-time residential students**, regardless of grade and year of study.

10At residential schools with lower grades: the requirements apply to residential students in grades pre-K through 8 **only** if the school combines these grades in the same school or part of a school with students in grades 9-12.

Open Arms Child Care Center Address and Telephone Release

I give permission for Open Arms Child Care to release my address and/or telephone number to parents within the program for the purpose of birthday parties or special events. I understand that this information will not be released for any other purpose or to any other parties.

_____ Permission to release address

_____ Permission to release telephone number

Child's Name

Parent's Signature

Date

OPEN ARMS CHILD CARE CENTER CONSENT FORM

While your child is enrolled at Open Arms he/she will be involved in a number of special activities for which we need your permission. Please read the following information carefully. You are encouraged to ask questions about anything which is unclear to you.

Please circle your choice:

- **I DO / DO NOT** give my permission for my child to go for supervised walks on Open Arms property.
- **I DO / DO NOT** give permission for sunscreen to be applied to my child. (Parents must provide sunscreen and we will not apply sunscreen to children under six months of age.)
- **I DO / DO NOT** give permission for my child to be screened for specific educational needs. All recommendations will be kept confidential and shared only with parents.
- **I DO / DO NOT** give permission for my child to be observed during general classroom observations or by student teachers. (All names will be kept confidential.)
- **I DO / DO NOT** give permission for my child to be photographed for Center use. (Including Open Arms publicity and classroom use.)
- **I DO / DO NOT** give permission for my child to be involved in fundraising events at Open Arms Child Care Center (i.e. Easter Seals Hop-a-thon). I understand that all fundraising events are optional.

Child's Name

Parent's Signature

Date

This form expires one year from date signed

Open Arms Child Care Center E-Mail Message Service

_____ No, I do not want to participate in the e-mail message service.

_____ Yes, I would like to participate in the e-mail message service.

Parent's/Guardian's Name: _____

Child's Name: _____

Child's Classroom: _____

E-Mail Address: _____

Parent's Signature

Date



A simple choice; a generous response

The *Simply Giving*® Program

Through *Simply Giving*®, your offerings or tuition payments are made through a pre-authorized withdrawal from your bank account. You determine the frequency of your automatic donation – weekly, semi-monthly, or monthly – the option is yours. **Note: The date the monthly tuition payment is transferred from your account to the school account is predetermined by the school.** Your donation or payment is deposited into the recipient's bank account on the same day it is withdrawn from your account.

Benefits to you and...

Your Congregation

Simply Giving® is a reliable, safe way to move your stewardship plan into action. It allows you to share your donations through planned giving and activates your generosity into ongoing stewardship. Because your donation is given consistently, you won't need to play "catch-up" at year-end or worry about forgotten checkbooks or missed Sunday offerings. But you're not the only one that benefits. Your congregation benefits from steady, more predictable revenues throughout the year, more efficient bookkeeping, and greater confidence in meeting its financial commitments.

Your School

This program is also a convenient way to pay tuition at a Lutheran school. *Simply Giving*® provides an easy, no-cost way for the school to collect tuition, and allows the school to benefit from consistent cash flow. Your tuition payments are made to the school through a pre-authorized withdrawal from your bank account and deposited on the same day into the school's bank account.

Your Favorite Lutheran Institution

You can also make convenient contributions to other Lutheran institutions through the *Simply Giving*® program. Because of your planned giving and ongoing stewardship, the institution you support benefits from steady, more predictable revenues throughout the year. This helps the institution to better meet its financial goals and development objectives.

Why does Thrivent Financial for Lutherans offer the *Simply Giving*® program?

Thrivent Financial for Lutherans offers *Simply Giving*® to further its mission of serving Lutheran congregations and institutions.

Who do I call if I have more questions about the *Simply Giving*® program?

Contact the institution benefiting from your giving. Your Thrivent Financial representative may also be able to answer your questions.

How do I cancel or change my authorization?

Contact the institution benefiting from your giving.

How do I participate?

First make sure the institution you wish to benefit is enrolled in *Simply Giving*®. Then complete the form on the reverse side and return it to the congregation or institution that will benefit from your giving.

ENROLLMENT INSTRUCTIONS:

1. Using black ink, complete the personal information section including name, address and telephone numbers.
2. Indicate whether this is a new enrollment/authorization, a change in amount, or a change in bank account.
3. Indicate the account type, routing number and account number. Attach a voided check or savings deposit slip to the enrollment form for a new enrollment or change in bank account.
4. **Sign and date the Account Holder Signature section.**
5. Complete the appropriate section with the institution name and address that will benefit from your giving.

For Your Lutheran Congregation Offering:
 - Designate which fund(s) your donation should go to and the amount.
 - Select the frequency of your offering.For Your Lutheran School Tuition:
 - Calculate the amount of each monthly tuition payment.
 - Determine the date of your first and last payment.For Your Lutheran Institution Donation:
 - Select the date of the monthly donation transfer and the amount of each monthly donation.
 - Determine the date of your first and last donation.
6. **Return the completed enrollment form to the Lutheran congregation, school or institution benefiting from your giving.**

PRIVACY / CONFIDENTIALITY: The Authorization Form on the back is seen by the nonprofit Lutheran organizations enrolled in *Simply Giving*® as well as by the Vanco Services employees who process it. In addition, participant name and address information may be provided to Thrivent Financial for Lutherans. Participant information will not be shared with any other organizations.

See reverse side for Authorization Form.