REVISED 2023 # ENROLLMENT FORMS Must be returned before 1 week of start date

The Barnesville Child Day Care Center is an equal opportunity employer

| **Name:** | **Date of birth:** | **Male**<br><br>**Female** |
|---|---|---|

**ADDRESS(physical)_____mailing address _____**
**if different**

**CITY, STATE, ZIPCODE_____**

**Communication information:**

| | **Mother** | **Father** |
|---|---|---|
| **address( if different)** | | |
| **cell phone** | | |
| **e-mail** | | |
| **place of employment**<br><br>**phone number** | | |

**Family information; other members of the household**

| **Name** | **Age** | **Relationship to child** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**CHILD'S PHYSICIAN_____ PHONE #_____**

**CLINIC AND ADDRESS_____**

**HOSPITAL_____**

**ADDRESS_____PHONE#_____**

**CHILD'S DENTIST_____**

**ADDRESS_____ PHONE#_____**

**Authorized to pick up child & emergency contacts: people who live close in case you cannot be reached**

| **Name** | **Address** | **Home phone & cell's** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |

**PARENT'S SIGNATURE_____date:_____**

**Schedule Times (10 hours)**

| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
|---|---|---|---|---|
| | | | | |

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Parent's Report PREADMITTANCE QUESTIONS
(please use this form to better acquaint us with your child and family)

1. Has your child ever been left in the care of others or for an extended period of time? Yes No

   Has your child had group play experience? Yes No

2. What are some of your child's interests/likes:
   Favorite toys:
   Favorite activities:
   What are some of their dislikes:
   Any fears:
   Any special problems?

3. What are some behaviors that you particularly enjoy?

4. What behaviors do you find hard or difficult to deal with?

5. How does child get along with siblings, parent, or other children?

6. How do you comfort your child?

Discipline: How do you/others handle inappropriate behaviors?
(We have our discipline policy plan in our parent handbook)

Children at the Center will generally be redirected when conflicts occur and will be provided with immediate and directly related consequences for unacceptable behavior. You will be contracted upon repeated behavior problems to discuss further methods of modification. Is this acceptable to you? Yes No
If not, we will need to have a meeting to discuss alternatives

Rest time/sleeping patterns:
Children 36 months and older are required to rest 30 minutes (each child will have their own cot and should use their own blanket [you will be responsible for laundering blankets] to lay quietly for the rest time), is this adequate rest for your child? We have at least ½ hour of settle down time before rest time.
If not, what rest period would better meet the needs of your child?

Do you have any special ways of helping your child settle in and rest?Yes____No___describe:

What is your child's present sleeping schedule:

Night time: _____ to _____ AM nap: _____ to_____ PM nap: _____to_____
Does your child/baby cry when going to sleep? Yes___No___
All infants are laid on their back when they sleep

*Does your baby need a pacifier for rest? Yes___No___
BRING A FAVORITE BLANKET FOR REST….please put name on it!

It is helpful to the staff to know when your child has had a difficult night to better take care for their needs.

Please read our parent policies to get a better understanding of our program. Schedule time to discuss these matters with the staff so that can take the best possible care of your child

Parent's Report **HEALTH STATEMENT**
Date:_____ PLEASE COMPLETE BEFORE ADMISSION

CHILD'S NAME_____ DATE OF BIRTH_____

Parent's evaluation of child's health: _____
Frequent ear aches_____ Frequent colds_____Epilepsy_____ChickenPox_____Diabetes_____ Hives____

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Asthma_____Eczema____ Drug/food intolerance_____Insect Stings_____Wheezing_____ Hay fever_____

Seizures/convulsions_____Measles_____Mumps_____Premature birth____Birth defect or injury_____

Trouble breathing at birth_____ head injuries_____Frequent Sore throat/w fever_____

Concerns about speech_____vision_____hearing_____

Is your child taking any medication now?_____what_____why_____

Is your child under the supervision of a physician_____ date of last exam_____

Is your child under the care of a specialist?____Who_____for what:_____

Other illnesses or ACCIDENTS_____

Has your child been hospitalized?_____when_____why_____

Does your child have any handicaps/special needs?_____what_____
Will we be able to care for your child within out group ratios?

Any other medical concerns we should be aware of:_____
WHAT ARRANGEMENTS HAVE BEEN MADE FOR THE CARE OF YOUR CHILD IF HE/SHE BECOMES ILL AT THE CENTER?_____

FEEDING: We are contracted with the Child Care Food Program and follow their menu and criteria to meet the needs of all children eating here. We will be following their recommendations for infant meals as well. Each year you will need to fill out a confidential income sheet to help us get reimbursed for each meal we serve.
Does your child have any feeding problems: Yes_____No_____

If yes, describe:_____

INFANT FEEDINGS: We provide Parent's Choice(Sam's Walmart brands) formula, bottles and nipples

- Is your baby breast fed?_____or bottle fed?_____
- Type of bottle_____type of nipple_____
- How many ounces taken between burps?_____
- What is your child's present eating schedule?
  (Specify amount and time for fluids[milk/formula/juice] and foods)

TODDLERS/PRESCHOOL/SACC MEALS: Please share with us any food problems/concerns you may have)
Breakfast_____(7:30-8:30) _____
Lunch_____(11:30)_____PM Snack_____3 pm-4pm_____

TOILETING: Policy statement: all children that are to be toilet trained will need to wear easy to remove clothing (no snaps, buttons, zippers, overalls, onsies, etc) All children will need to be READY to be toilet trained and responsive to voice information concerning using the toilet. All children will need plenty of extra clothing here at the Center.

1. Is your child toilet trained? Yes____ No____

2. What words does your child use for urination?_____for bowel movements?_____

3. How frequently does you child have a bowel movement? _____appearance_____
   Any concerns:_____

INFANTS:

- Does your child get frequent diaper rashes?_____

- How do you treat diaper rash?_____
  (we will need you to bring diapers, wipes and any rash treatments) SEE PERMISSION FORMS

BRING EXTRA CLOTHING TO LEAVE AT THE CENTER. Mark all items.

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(we have many needs for extra clothing(spills, illness, painting, etc.)

Do you have any concerns about the following issues?

- Meal time:
- Rest time:
- Acting out behaviors:
- Field trips
- Special diets:
- Medical problems:
- Toileting:

Other concerns:

PLEASE TALK TO YOUR CHILD'S MAIN CARE GIVER IF YOU HAVE ANY CONCERNS OR THE ADMINISTRATIVE STAFF. We want to help your child and you feel comfortable at the Center. Each child is mandated to have 2 conferences per year. Our procedure for family/parent interactions is informal; however you may request a conference at any time. It is our intent to keep in contact with you daily through infant/toddler daily sheets and to visit with you at drop-off and pick-up times.

Name of child:_____

Publicity and Research :

I give permission to the BCDCC to have my child participate in publicity and/or research projects/activites at the Center. I understand I will be notified of the dates and times of these activities when possible.

Field Trips:

I give permission to the BCDCC to take my child on supervised walks, field trips that may or may not require transportation. I understand that I will be notified of field trips in advance and will be able to decide per event if my child may or may not attend.

Emergency measures:

I give to the BCDCC permission to take whatever emergency (e.g. first aid, disaster evacuation, etc.) measures that are judged necessary for the care of my child.

Medical Emergency:

In case of a medical emergency, I understand that 911 will be called and my child will be transported to the appropriate medical facility for any treatment required.

I understand that in some medical situations the staff will need to contact the local emergency resources before the parent, child's physician, and /or other adults acting on the parent's behalf.

INSURANCE COMPANY_____POLICY #_____

Parent/ Insurance will be responsible for any medical bills.

I have discussed and been made aware of the BCDCC policies. I understand that copies of the policies are available to me.

Contract:_____ Emergency policy:_____
Parent policy:_____ Grievance policy:_____
Discipline policy:_____ Field trips:_____
Health policy:_____ Sick Child Care policy:_____
Abuse policy:_____ Child Care Credits:_____
Medication Slip Policy:_____ Mandated Reporting Policy:_____

Signature_____

*reminder immunization must be at the Center before admission. You may fill this out and must give us updated shots records.

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**You and Doctor sign the form below**

I hereby give my permission to the staff of the BCDCC to administer the following products according to their instructions. ALL OTC(over the counter) medication must have prior permission from your child's physician. This form may be copied and taken with you each time you need to update information!

THESE PERMISSION SLIPS MUST BE KEPT UDATED AS YOUR CHILD GROWS TO MEET THEIR NEEDS FOR OTC'S.

Over the counter meds:

Childs full name _____Date of Birth_____

Doctor permission needed:

| No | Yes | Products: | No | Yes | Products: | No | Yes | Products: |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Diaper wipes | ___ | ___ | Baby Power | ___ | ___ | _____ |
| ___ | ___ | Diaper ointments | ___ | ___ | Vaseline | ___ | ___ | Rash ointments |
| ___ | ___ | Baby Lotion/oil | ___ | ___ | Shampoo | ___ | ___ | Teething otc's |
| ___ | ___ | Liquid/bar Soap | ___ | ___ | Toothpaste | ___ | ___ | Cough syrup |
| ___ | ___ | Suntan Lotion | ___ | ___ | Insect repellent | ___ | ___ | Aspirin |
| ___ | ___ | Band aids | ___ | ___ | Chap lip | ___ | ___ | Aspirin free |
| ___ | ___ | Adhesive tapes | ___ | ___ | Nail polish | ___ | ___ | Sinus medication |
| ___ | ___ | Make up | ___ | ___ | Body paint | ___ | ___ | Antiseptic & burn ointments |
| ___ | ___ | Body glitter/gel pens | ___ | ___ | Removable tattoos | ___ | ___ | Mentholatum Rubs |
| ___ | ___ | Lip stick | ___ | ___ | Hair products | ___ | ___ | Hydrogen Peroxide |
| (the children like to play in the beauty shop play center, and with supervision are allowed to use products) | | | | | | ___ | ___ | Itching Creams |
| If you do not want your child to do this it must be clear to everyone especially your child!! | | | | | | ___ | ___ | Antiseptic wipes |
| Others:_____ | | | | | | ___ | ___ | |

Parent signature and date_____ Physician's signature and date :

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All prescription medications must come with written instructions; be in the original container and will be given only as prescribed per physician's instruction. We will not give any meds/OTC's via phone conversations. Please have all medication forms filled out properly so that we can proceed.

Date of last examination:_____

How long have you been seeing this child_____

Consider the health history and your complete examination, please comment on the following:

1. Does the child have a physical condition that one of the immunizations would seriously endanger the health of the child?
   No_____Yes_____(explain)

2 Does the child have a condition that would limit participation in the Center's program?
   No_____Yes_____(explain)

3 Does the child have a condition that may result in an emergency?
   No_____Yes_____(explain)

4 Is a special diet necessary for this child?
   No_____Yes_____(explain)

5 Is this child developing normally for his/her age?
   Yes_____No_____(explain)

6 Are there any other concerns health/wise that we should be aware of?

It is our policy to have the physician give permission for OTC medications, please address this with parents and indicate what OTC's are permissible to give this child at this age. Also please provide current immunization

Doctor Signature and date_____

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