REVISED 2011

ENROLLMENT FORMS

The Barnesville Child Day Care Center is an equal opportunity employer

Name:	**Date of birth:**	**Male** **Female**

ADDRESS(physical)__________________________________**mailing address** ___________________________________
if different

CITY, STATE, ZIPCODE____

Communication information:

	Mother	**Father**
address(if different)		
home phone		
cell phone		
e-mail		
place of employment **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:**_____________

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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.

Signed ______________________________Date:__________

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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____

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:____

<u>INFANT FEEDINGS</u>: 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)_____________________AM Snack______10am________________________
Lunch__________(11:30)________________________PM Snack______3 pm-4pm____________________

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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.
(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.

Signed __________________________ dated________________

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You will need 2 copies of page 5; one for us at admittance and one for your physician to fill out. Thanks

PERMISSION SLIPS

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.

No	Yes	Products:	No	Yes	Products:	No	Yes	Products: (Over the counter meds: Doctor permission needed:)
___	___	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
						___	___	Itching Creams
						___	___	Antiseptic wipes
						___	___	
						___	___	______________

(the children like to play in the beauty shop play center, and with supervision are allowed to use products)
If you do not want your child to do this it must be clear to everyone especially your child!!

Others:____

____

Physician's signature:
Date:

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.

It is imperative you have a back-up plan for sick child care.

Signature:__________________________ Date:________________

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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.

Health reports:

I give the BCDCC permission to contact my child's medical care provider's if necessary to obtain information necessary for his/her health for the safety of the other children or in order to verify the child's health status.

NAME:	DOCTOR:	DENTIST:	HOSPITAL:
NAME:			
PHONE NUMBER			

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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PHYSICIAN'S STATEMENT

Child's Name:______________________
Parent's Name:_____________________

Please return medical information and immunization to:

Barnesville Child Day Care Center
405 2nd Street SE
P.O. Box 383
Barnesville, MN 56514

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?**

<u>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.</u>

Signature of Physician_________________________

Date:_______________