Enrollment Agreement

Enrollment Information

Please complete this Enrollment Agreement accurately and completely, as this information is necessary for Discover Little Miracles to comply with state child care licensing regulations, as well as to understand your child and meet his or her individual needs. Completion of the Enrollment Agreement is required prior to enrollment at Discover Little Miracles.

CHILD INFORMATON			
Last Name	First Name	Middle Name	Nickname
DOB	○ Male ○ Female	Child's Primary Language	Parent's/Guardian's Primary Language
Home Address	City State Zip		Home Phone
List family members your child lives with – include names/ages of siblings			
Program ○ Infant ○ Toddler ○ Preschool 1st day of attendance:	Schedule: ○ Full-time ○ Drop-in ○ Mon ○ Tues ○ Wed ○ Thurs ○ Fri Contract Hours:		

PARENT/GUARDIAN INFORMATION			
PRIMARY PARENT/GUARDIAN	DOB	Relationship to Child	
Social Security #	Mother's Maiden Name	**Note:** Personal information is used for verification purposes.	
Home Address	City State Zip		
Home Phone	Cell Phone	Work Phone	E-mail Address
Employer and Address		Work Hours:	
SECONDARY PARENT/GUARDIAN	DOB	Relationship to Child	
Social Security #	Mother's Maiden Name	**Note:** Personal information is used for verification purposes.	
Home Address	City State Zip		
Home Phone	Cell Phone	Work Phone	E-mail Address
Employer and Address		Work Hours:	

EMERGENCY CONTACT AND RELEASE PERSONS – OTHER THAN PARENTS/GUARDIANS

For the protection of your child and in any emergency situation which may arise, please list on the next page the names and contact information of those persons **other than yourself** you hereby authorize to pick up your child from the center. Emergency contacts must not include people residing in your household, but friends or other family members who do not live with you and are familiar with your child. Discover Little Miracles will only release your child to adults (age 18 and up) you designate as authorized. It is our policy to ask all unfamiliar adults for photo identification. If possible, please notify the center if someone other than the primary or secondary parent/guardian will be picking up your child on a given day.

Emergency Contact/Authorized Person #1 (other than parent)	Relationship to Child	Home Phone	Cell Phone
Home Address City State Zip	E-mail Address		Work Phone
Emergency Contact/Authorized Person #2 (other than parent)	Relationship to Child	Home Phone	Cell Phone
Home Address City State Zip	E-mail Address		Work Phone
Emergency Contact/Authorized Person #3 (other than parent)	Relationship to Child	Home Phone	Cell Phone
Home Address City State Zip	E-mail Address		Work Phone

HEALTH AND DEVELOPMENTAL HISTORY

Child's Name: DOB:

CHILD'S BASIC INFORMATION

Height	Weight	Hair Color	Eye Color	Distinguishing Marks

GENERAL HISTORY

1. Has your child had previous child care experience? If yes, please list location(s) of previous child care experiences: ○ Yes ○ No
   _____
2. Is your child ○ left-handed or ○ right-handed? ○ N/A – has not been developed yet
3. What is your child's favorite toy(s)? _____
4. What is your child's favorite play activity? _____
5. Special interests of your child: _____
6. How do you comfort your child? (i.e., use of pacifier, blanket, stuffed animal, physical touches such as hugs)_____

HEALTH HISTORY

1. Does your child seem healthy most of the time? ○ Yes ○ No
2. Is your child taking any medication now? If yes, what? _____ Why? _____ ○ Yes ○ No
3. In the past year has your child had any ear infections? ○ Yes ○ No
4. In the past year has your child had any colds or sore throat infections with a fever? ○ Yes ○ No
5. Has your child had trouble with his/her eyes or vision? ○ Yes ○ No
6. What arrangements have you made for the care of your child should he/she becomes ill at the center? _____
7. Does your child have any special needs that the staff should be aware of? Please attach a copy of your child's IEP/ICCP, if applicable. ○ Yes ○ No
   If yes, please explain: _____
8. Does your child have, or ever had, other illnesses or diseases the staff should be aware of? If yes, list type, when and how treated. ○ Yes ○ No
   _____
9. Has your child ever been hospitalized? If yes, for what? _____ ○ Yes ○ No
10. Has your child ever had any serious accidents or poisonings? If yes, list type, when, and how treated. _____ ○ Yes ○ No
11. Has your child ever been seen by a medical specialist? If yes, who? _____ Why? _____ ○ Yes ○ No
12. Check any of the following your child has ever had:
    If yes, to any, please describe: _____
    _____
    _____
    _____

Premature birth	○ Yes ○ No
Trouble breathing at birth	○ Yes ○ No
Birth injury or defect	○ Yes ○ No
Head injury	○ Yes ○ No
Seizures or convulsions	○ Yes ○ No

EMOTIONAL BEHAVIOR

1. Every child, at one time or another, exhibits the behaviors listed below. Please indicate which words you feel are most applicable for your child.
   ○ Generally Cheerful ○ Quiet ○ Talkative ○ Group Leader ○ Cooperative ○ Physical ○ Calm
   ○ Easily Excited ○ Outgoing ○ Group Follower ○ Sensitive ○ Active ○ Independent ○ Often Shy
2. List other comments you may have regarding your child's behavior: _____
3. What behavior do you consider most difficult to deal with? _____
4. What fears does your child have? Describe the history and how the child shows fear. _____
5. Is there anything you think, that we, as teachers, should know about your child to help us work with him or her more effectively? Please include cultural preferences. _____

DAILY ROUTINES - INFANTS

1. Does your baby cry when going to sleep? ○ Yes ○ No
2. Does your child need a pacifier ○ Yes ○ No
3. Is your baby: ○ breast fed ○ bottle fed what type of bottle? _____ what type of nipple? _____
4. Does your baby have any special feeding requirements? If yes, please indicate: _____ ○ Yes ○ No
5. What is your child's present eating schedule? List type and amount of food:

	Solid Foods	Juices	Formula/Breast Milk/Milk
Breakfast			
Lunch			
Snack			

DAILY ROUTINES – INFANTS/TODDLERS/PRESCHOOLERS

1. Do you have any special ways of helping your child go to sleep? _____
2. What is your child's present sleeping schedule? Night time _____ to _____ AM Nap _____ to _____ PM Nap _____ to _____
3. Does your child need a blanket or toy for sleeping? ○ Yes ○ No

TOILETING

1. How frequently does your child have a bowel movement? _____
2. Is your child toilet trained? ○ Yes ○ No
3. What word does your child use for urination? _____ Bowel movement? _____
4. Does your child use a potty chair? ○ Yes ○ No
5. Does your child frequently have a diaper rash? If yes, how is it treated? _____ ○ Yes ○ No

Please attach additional pages to list any additional comments you may have relating to any aspects of your child's health or developmental history.

This area for office use only	Center:	Enrollment Date:

Child's Name:	DOB:

HEALTH AND DEVELOPMENTAL HISTORY

ALLERGIES

1. My child does have food or environmental allergies, asthma, or special food accommodations as determined by a physician or religious preferences. ○Yes ○No
   If yes, please continue on to question 2. If no, please go on to the next section.
2. My child has allergies (please check all that apply). If checked, please fill out form A-500 (Emergency Care Plan for Child with Severe Allergies) Appropriate prescription and non-prescription medication release forms (M-200, M-300, or M-400 Medication Release and Over-the-Counter Allergy Medication). ○ Food Allergies ○ Environmental Allergies
3. My child has asthma. If yes, please fill out form A-600- Asthma/Reactive Airway Disease (RAD) Individual Care Plan along with appropriate prescription and non-prescription medication release form M-200 (Prescription Medication Authorization/Administration form). ○Yes ○No
4. My child has special diet accommodations (including allergies, food intolerance, and/or cultural/religious preferences). If yes, Please fill our form A-400 Allergy/Diet Restrictions/Diet Modification Log and/or, A-500 Emergency Care Plan for Child with Severe Allergies. ○Yes ○No

MEDICAL PROVIDERS AND HEALTH INSURANCE INFORMATION

Primary Care Physician (PCP) Name		Practice/Clinic Name		
PCP Address	City	State	Zip	PCP Phone
Preferred hospital/clinic for acute care and emergency care				
Hospital/Clinic Address	City	State	Zip	Phone
Dentist Name		Practice/Clinic Name		
Address	City	State	Zip	Phone
Health Insurance Provider and Policy Number		Secondary Health Insurance Provider and Policy Number		

Parents are notified immediately if an illness or injury requires immediate medical attention. In an emergency situation, we contact 911 first and then contact Family.

MEDICAL POLICIES

1. Prior to enrollment, you must provide the center with updated medical and immunization information for your child (Form H-300). This information must be updated each time your child enters a new program (i.e., transitions from infants to toddlers, from toddlers to preschoolers, etc.). Children without appropriate and current medical records may not attend the center.
2. You must promptly provide the center with any information regarding conditions, illnesses, allergies, or other special needs that may require specific care or attention, and agree to provide additional documentation as needed.
3. In the event your child becomes ill at the center, you must pick up your child within one (1) hour of us notifying you.
4. If your child contracts a reportable contagious disease, your child may only return to the center once they are no longer contagious. A physician's note may be required.
5. Your child may be excluded from the center if he or she:
   - Has tympanic (ear) temperature of 101° or higher; your child should stay home until he or she is fever-free for 24 hours without the aid of fever-reducing medicine.
   - Has vomited two or more times since admission that day (the center to use discernment)
   - Has contagious pink eye (conjunctivitis) or drainage from the eye
   - Has any rash that may be disease-related or the cause is unknown; please check with your family physician before sending your child to the center
   - Has had three or more loose stools since admission that day
   - Has a bacterial infection such as Streptococcal or Impetigo and has not completed 24 hours of antimicrobial therapy
   - Has unexplained lethargy
   - Has lice, ringworm, or scabies that is untreated and contagious to others
   - Is experiencing significant respiratory distress
   - Is not able to participate in the child care program activities with regular comfort
   - Requires more care than the program staff can provide without compromising the health and safety of other children

This area for office use only	Center:	Enrollment Date:

ENROLLMENT AGREEMENT

FINANCIAL POLICIES

Child's Name:	DOB:

TUITION POLICIES

Discover Little Miracles policy is to charge tuition in advance of the week services are provided. Tuition payments for each child enrolled with Discover Little Miracles are due on Thursday for the upcoming week. A late fee, of $2.00 per day, will be assessed to all accounts that are not current on Thursday at noon. If Discover Little Miracles fails to receive your tuition payment by the following Thursday your child's enrollment will be terminated and Discover Little Miracles will pursue collection remedies for all unpaid tuition and associated costs, disbursements, and attorney's fees. In order to provide the best child development at Discover Little Miracles, we must budget for everyday costs associated with our staff, food, and supplies. Discover Little Miracles requires full tuition during a holiday week. Discover Little Miracles budgets on scheduled enrollment, and therefore will not issue a refund on tuition if your child is absent. Receipt for payment is available upon request. Discover Little Miracles financial policies are subject to change without notice.

ENROLLMENT SCHEDULES

All enrolled children must have a schedule. All enrolled children must check in and out every day.

Full-time: Full-time enrollment includes Monday-Friday up to 10 hours a day that you will choose at the time of enrollment. If you need to change your hours, a new contract will need to be filled out at least 2 weeks prior to the change going into effect.

Flexible Schedule: Discover Little Miracles will make every effort to accommodate families with work schedules that vary from week to week. We require that your family submit a schedule in writing to the center director on Tuesday of the prior week so that we may staff accordingly. Your weekly tuition will be billed according to the schedule you submit each Tuesday. If we do not receive a schedule for the upcoming week, your account will be charged based on your previous week's schedule. All families utilizing a flexible schedule will be charged tuition for the six legal holidays plus one additional day for professional development. Flexible schedules will only be available when classroom occupancy allows. Once a classroom can no longer accommodate a flexible schedule, you will be given the option of a part-time or full-time schedule. As well, if you continue to use the same days each week, the center director will automatically convert your family to the appropriate enrollment schedule.

Drop-in Care: Drop-in care may be available when space allows. You will need to verify availability each time you need care. Space cannot be guaranteed. Times are rounded to the next hour for calculation of hourly charges. Prepayment for the estimated tuition charge is expected at the time your child is dropped off. Discounts and coupons are not available for drop-in care.

CREDIT POLICY

After your family's enrollment has been continuously maintained for one year, you can earn one week of credit time. Earned credit time can be used when your child is absent for any reason. Credit time may be used in any increments that you choose; however, you will be charged the daily rate for the number of days attended. At no time is credit given while your child is in attendance. If your family has not yet accrued earned credit time, Discover Little Miracles expects full tuition when your child is absent.

COLLECTION POLICY

At the sole discretion of Discover Little Miracles, any account balance that includes two or more weeks of unpaid tuition may be pursued for payment collection. If necessary for Discover Little Miracles to engage in legal action, the family involved will be responsible for all costs and expenses including attorney's fees. Parents are responsible for all costs and expenses, including attorney's fees, incurred in the collection of any fees due from their account, and/or defending any lawsuit brought by the family in which Discover Little Miracles prevails. Such costs and expenses also include, but are not limited to, court costs and bank charges.

I certify that I have read, understand, and accept all of the terms and conditions described in these financial policies. This agreement is effective the date signed below.

Primary Parent/Guardian Signature:	*Date:*	*Secondary Parent/Guardian Signature:*	*Date:*

I certify that I have reviewed the financial policies with the primary and/or secondary parent/guardian.

Director Signature:	*Date:*

This area for office use only	Center:	Enrollment Date:

ENROLLMENT AGREEMENT
FEE SCHEDULE

Child's Name:	DOB:

FEES AND CHARGES

1. **Registration Fee:** Discover Little Miracles requires a registration fee of $100 at the time of enrollment. This fee, along with the cost of the first week of tuition may be prepaid to reserve a spot for your child. The registration fee and first week of tuition are non-refundable.

2. **Annual Renewal Fee:** Discover Little Miracles requires an annual registration fee of $50, charged each September.

3. **Field Trip:** Discover Little Miracles may offer field trips throughout the course of the year to supplement our preschool curriculum. All Discover Little Miracles field trips are optional. A separate fee will be charged for each child to participate.

4. **Late Payment Fee**: Tuition is due on Thursday morning for the upcoming week. Any accounts that are not current on Thursday at noon will result in a late fee of $2 per day assessed to your account.

5. **Late Pick-Up Fee:** A $15 per child fee will be charged if you drop off/pick up your child outside of your contract hours. In addition, a late pick-up fee of $1 per minute, per child, will be assessed to your account in the event your child has not been picked up before closing time. This fee covers Discover Little Miracles costs of providing childcare professionals beyond our usual hours of operation. The charge will be assessed for each child remaining after closing, in increments of 1 minute.

6. **Returned ACH** (Automated Clearing House): A service charge of $30 will be assessed on all returned ACH's.

DISCOUNTS

1. **Sibling Discount:** At Discover Little Miracles, families with more than one child receive a discount on tuition for the second and any subsequent children. A 10 percent sibling discount is given on the least expensive programs. The sibling discount cannot be combined with any other offer.

2. Discounts are not given on registration fees, field trip fees, transportation fees, or late fees.

I understand that my rate may change. As my child transitions to a new classroom, if my child's schedule changes and results in a different fee schedule, or if rates change, my rate will be adjusted accordingly.

I hereby agree to and accept the fee schedule as outlined above.

Primary Parent/Guardian Signature:	*Date:*	*Second Parent/Guardian Signature:*	*Date:*

REVISION TO FEE SCHEDULE

Date Revision Effective (page 5 only) _____

Primary Parent/Guardian Signature _____

Secondary Parent/Guardian Signature _____

Center Director Signature _____

This area for office use only	Center:	Enrollment Date:

ENROLLMENT AGREEMENT
OTHER TERMS AND AUTHORIZATIONS

Child's Name:	DOB:

OTHER TERMS – By Signing below, I agree to the following terms.

1. Discover Little Miracles policies and programs are subject to change.
2. I understand and agree that I must notify the center by 9:00 a.m. when my child is absent.
3. I understand and agree to promptly update the enrollment agreement if there is a change in any information provided in the agreement. If you would like to terminate care a two-week written notice is required. Fees will still be charged during this time.
4. I agree to give Discover Little Miracles permission to communicate with me by telephone, e-mail, or other means. When necessary, written communication may be sent home with emergency contact and release persons.
5. Discover Little Miracles may disenroll a child without prior notice if, in the sole opinion of Discover Little Miracles, it is in the best interest of the child or Discover Little Miracles.
6. State licensing regulations are on file at the center and are available upon request.

AUTHORIZATIONS

Walking Field Trips

I authorize Discover Little Miracles to take my child on walking field trips within the local area for educational outings, and other center-sponsored events.
I understand that my child will always be under appropriate supervision.
I will authorize specific field trips by signing the Field Trip Authorization Form for each walking field trip my child participates in.

Parent/Guardian Signature: Date:

o Yes o No

Photographs/Videotape/Facebook: Private

I authorize Discover Little Miracles to photograph and/or videotape my child during the program and field trips. I give permission for Discover Little Miracles staff to post pictures and videos of my child to the private Facebook page: **St. Michael D.L.M. Families** that is accessible **only** to approved family members of children currently enrolled at Discover Little Miracles.

Parent/Guardian Signature: Date:

o Yes o No

Photographs/Videotape/Facebook: Public

I authorize Discover Little Miracles to photograph and/or videotape my child during the program and field trips. I give permission for Discover Little Miracles staff to post pictures and videos of my child to the public Facebook page:
Discover Little Miracles Child Care – St. Michael, MN that is accessible to the **public**.

Parent/Guardian Signature: Date:

o Yes o No

Professional Portrait Authorization

I authorize a professional portrait company to take individual and class portraits of my child. The photos will be available for purchase – not for publicity, marketing, advertising etc. by Discover Little Miracles. For tracking purposes, my child's name and class will be given to the photographer. A Discover Little Miracles staff member will always be present during photograph sessions.

Parent/Guardian Signature: Date:

o Yes o No

Nurse/Health Consultant

I understand that Discover Little Miracles nurse/health consultant has access to my child's file during center visits.

Parent/Guardian Signature: Date:

FAMILY HANDBOOK

I have been given a copy of the Discover Little Miracles Parent Handout and I have read the booklet and all policies and procedures. I am aware of the terms and conditions of enrollment, which together with this Enrollment Agreement shall constitute a binding agreement between Discover Little Miracles and the undersigned. I understand it is my responsibility to ensure that my child care fees are paid in full and in a timely manner.	Parent/Guardian Signature: Date:

I certify that I have read, understand, and accept all the terms and conditions described in this agreement. This agreement is effective the date signed below.

Primary Parent/Guardian Signature:	*Date:*	*Secondary Parent/Guardian Signature:*	*Date:*

This area for office use only	Center:	Enrollment Date:

My Teacher Wants to Know

CHILD'S NAME: DATE:

How well do I:	Not so well — Very well (1 — 3 — 5)
do in the morning?	
do in the afternoon?	
do in the evening?	
sleep?	
nap?	
eat lunch?	
eat dinner?	
play with adults?	
play by myself?	
play with another child?	
play in a small group?	
play in a large group?	
play inside?	
play outside?	
play with younger children?	
play with older children?	
do when children sit near me?	
do when children sit further away?	

How do I let people know:
I am angry or upset (example: crying, screaming, etc.)?
I am happy (example: laughing, hopping, etc.)?
I want something (example: reaching, talking, etc.)?
I don't want something (example: push away, say NO, etc)?
I like something (example: smiling, talking, laughing, etc)?
I don't like something (example: crying, throwing, talking, etc.)?
What helps me when I am: sad? angry? scared?
What makes me angry/upset?
What makes me happy/excited?

TTYC Expanding Teaching Tools for Young Children with Challenging Behavior

Lentini, R., Vaughn, B.J., & Fox, L. (2005). Teaching Tools for Young Children with Challenging Behavior. University of South Florida.

My Preferences:

1. My teacher wants to know about toys/activities:

My Favorite	My Least

4. My teacher wants to know about people in my life with whom I:

Behave Well	Have Behavior Problems

2. My teacher wants to know about foods:

My Favorite	My Least

3. My teacher wants to know what activities I like:

blocks/legos	dress up	pretend cooking
computer	coloring	paints
sand table	water table	books
cutting	pasting	play doh
baby dolls	cars/trains	outside play
action figures	real cooking	

other:_____

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/Immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

_____

What is the status of the child's. . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

MS-2083

Non-Prescription Medication Products Authorization Only

FORM M-400

All over-the-counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time you use them. The following is a list requiring parental permission only.

TO BE COMPLETED BY PARENT

Child's Name: _____ Date of Birth: ____/____/____
Program Name: _____ Today's Date: ____/____/____

The following external products may be applied to my child in accordance with the manufacturers instructions on the original container:

_____ Diaper wipes
_____ Diaper creams, ointments
_____ Skin lotions/creams/vaseline: specify if special brand: _____
_____ Baby oil; (baby powder is not recommended due to inhalation hazards)
_____ Soap, Brand Name: _____
_____ Sunscreen: specify if special brand: _____
_____ Insect repellants: specify if special brand: _____
_____ Lip balm
_____ Chemical hand sanitizers
_____ Toothpaste (an internal product but does fall under this category)
_____ Other – please specify: _____

NOTE: Teething gels are considered OTC medications not products (use **Form M-200**) Teething gels are not recommended and need to be used with extreme caution. They have been known to numb the throat which causes a potential choking hazard.

Parents/Guardian's signature required: _____

* Unused products: Returned to parents? Yes / No **or**, discarded appropriately (circle one)

by: _____ Date: ____/____/____

***Keep this form in the child's file when medication is finished.**

All oral OTC medications need Prescription (Form M-200) or Non-Prescription (Form M-300) Medication Authorization/Administration Form completed.

EMERGENCY CARD

Child's Name_____ Birthdate_____

Home Address_____

PHONE #

Parent Name_____ Home_____

Address_____ Cell_____

Work_____

Parent Name_____ Home_____

Address_____ Cell_____

Work_____

Emergency Contacts/Authorized Pick Up (at least 2, other than parents)

Name_____ Home_____

Address_____ Cell_____

Relationship_____ Work_____

Name_____ Home_____

Address_____ Cell_____

Relationship_____ Work_____

Name_____ Home_____

Address_____ Cell_____

Relationship_____ Work_____

I authorize the treatment of anesthesia and surgical treatment for my minor child _____ in the event of a medical situation occurring during my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing treatments consent form, which are deemed necessary for my minor child.

Physician_____ Clinic_____ Phone #_____

Address_____

Dentist_____ Clinic_____ Phone #_____

Address_____

Preferred Hospital for acute/emergency care_____ Phone #_____

Address_____

Insurance Name & Number_____

Allergies/Conditions_____

Parent or Guardian Signature_____ Date_____

Contract hours

_____ Contracted hours for Discover Little Miracles are stated below.

Your tuition rate as of _____ is _____ weekly and due on ***Thursday Mornings*** for the following week. (Payments received after Thursday at Noon will be charged a $2 late fee per day)

Monday	Tuesday	Wednesday	Thursday	Friday

You can drop off / pick-up your child anytime between your contracted hours (up to 10 hours). A $15 per child will be charged if you drop off / pick-up your child outside of your contract hours. After 6:00pm you will be charged $15, along with $1 per minute per child.

If you need to drop off / pick-up your child outside of your contract hours you must inform the director (Ms. Jenny) the Monday before the week you need the change. This will ensure us that staff are scheduled accordingly to stay in ratio.

Your contract hours can always be changed at any given time. The changes will take affect 2 weeks after it's received by the director (Ms. Jenny).

Parent / Guardian signature: _____ Date: _____

Parent / Guardian signature: _____ Date: _____

Thank you,
Ms. Jenny
Discover Little Miracles Director