DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child

Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)

Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No

Place of Employment and Work Phone No.

b. Name and Relationship to Child

Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)

Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No

Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child

Home / Cell Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

b. Name and Relationship to Child

Home / Cell Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child

Home / Cell Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name

Address (Street, City, State, Zip Code) | Telephone No.

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.

☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.

☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian | Date Signed

Health History and Emergency Care Plan

Use of form: This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian may complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Asthma
   - ☐ Cerebral palsy / motor disorder
   - ☐ Diabetes
   - ☐ Epilepsy / seizure disorder
   - ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

Child Health Report – Child Care Centers

Use of form: Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/20)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only two doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose four days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only two doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian — Date Signed

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.
Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren):	**Center**

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?
If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShare Wisconsin (10-digit case number):**
DO NOT list a 16-digit Quest Card number:
____

☐ **Wisconsin Works (W-2) Programs (10-digit case number):**
Wisconsin Shares Child Care Subsidy benefits is NOT a W-2 Program. It does not qualify a child as free in the CACFP.
____

☐ **FDPIR (9-digit case number):**
____

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) Household Members Information:
List full names of all members in first column, including yourself and all children.

b) List all income on the same line as the person who receives it.
- Record each income source only once.
- Check the box for how often each income source is received.

Household Member Names **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: _____

PART 3: SIGNATURE

An adult household member must sign and date this form
If PART 2 is completed, the adult signing the form ***must list the last four digits of their SS# OR*** *check "None" if they do not have a SS#.*

ETHNICITY AND RACE DATA COLLECTION – *Completion is optional*
This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	**Signature Date** *Mo./Day/Yr.*	**Last 4 digits of SS#** (or check "None" if you do not have a SS#) ***-**-__ __ __ __ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections

Section 1: Basis of Determining Eligibility *(A or B)*		**Section 2: Eligibility Determination**	**Section 3: Determining Official's Initials/Approval Date Effective Month of Determination**
A. Household Size & Income **Total Household Size** ______ ***Total Income $**______/______ ($ Amount) (Time Period)	***B. Benefits/Foster*** ☐ **FoodShare WI** ☐ **W-2 Programs** ☐ **FDPIR** ☐ **Foster Child(ren)**	☐ **Free** ☐ **Reduced** ☐ **Non-Needy**	**Initials/Date:** ____________ ****Effective Month of Determination:** ____________ **Month/Year**

*Convert to yearly income <u>only</u> when multiple pay frequencies are reported, using only these multipliers:	Weekly x 52 Every 2 weeks x 26	Twice a month x 24 Monthly x 12	**This form expires one year from the *Effective Month of Determination.*

CACFP
Child and Adult Care Food Program

CACFP ENROLLMENT FORM

Child Care Name:

Parent/Guardian Instructions:
This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child(ren), to meet the annual updating requirements.**

HOURS AND MEALS WHILE IN CARE

	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓) Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Child's Name:	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓) Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Child's Name:	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓) Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Child's Name:	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature (Year One): Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Two):* Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Three):* Date *Mo./Day/Yr.*

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
MEDICATION INFORMATION AND AUTHORIZATION

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Children's Day Center

Name – Child

Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period From	Dates – Medication Time Period To
Please check one: $5.00 - Fee for Summer OEquate SPF 50 (Provide by Children's Day Center) O Other (Provided by Parent)	2 tablespoons liberally Every 2 hours or 80 minutes due to sweat or swimming	☐ AM ☐ PM ☐ AM ☐ PM ☐ AM ☐ PM ☐ AM ☐ PM	Apply before sun exposure.		

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication

Parent Initials

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian

Date Signed

Children's Day Center

Sick Child Policy Amendment: COVID-19

The safety and wellbeing of all staff, children, and the families at Children's Day Center continues to be of utmost importance to us. We always commit to taking all precautions toward keeping children and staff safe and healthy, including the current time of the COVID-19 outbreak. Following this additional sick child policy will help Children's Day Center to do this.

Children will be monitored for signs or symptoms of COVID-19 daily. **Children will be asked to stay home or return home if any of the following applies:**

- Have a fever of 100.4 or higher
- Have diarrhea 3 or more times in 24 hours
- Have vomited at all in the last 24 hours
- Have had a fever of 100.4 or higher or other potential symptoms of COVID-19, such as shortness of breath or persistent dry cough, within the last 72 hours
- Have come in contact with others who have COVID-19

To prevent the spread of COVID-19:

- Children with signs/symptoms of COVID-19 or who have been exposed to others with COVID-19 will be asked to stay home
- Children who develop signs/symptoms of COVID-19 while at the program will be immediately separated from others and the program staff will contact the family member and/or emergency contact to pick the child up
- We encourage families to practice frequent handwashing at home
- Children's Day Center will continue to practice handwashing but will increase frequency to including but not limited to all of the following; upon arrival to the program, before meals and snacks, after outdoor play, after using the bathroom, prior to going home, after nose blowing or assisting a child with blowing their nose, coughing, or sneezing
- Cover cough and sneezes with tissues, throw tissues in the trash, and clean hands with soap and water as per our normal procedures
- Continue to clean and disinfect frequently touched surfaces at least daily, including tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks as often as possible while continuing to care for children appropriately

If an enrolled child or employee tests positive for COVID-19:

- The local public health department and the Department of Children and Families Bureau of Early Care Regulation will be contacted. Children's Day Center will follow their guidance for next steps
- The program will post and notify families of any confirmed staff or child cases of COVID-19 through email and Brightwheel.

Returning to a child care facility after suspected COVID-19 symptoms

If a staff member or child has symptoms of COVID-19 or is in close contact of someone with COVID-19, they can return to the child care facility if the following conditions are met:

- If an individual has a fever, cough or shortness of breath and has not been around anyone who has been diagnosed with COVID-19, they can return to the center no sooner than 72 hours after the fever is gone (without the use of fever-reducing medication) and symptoms get better. If the person's symptoms worsen, they should contact their healthcare provider to determine if they should be tested for COVID-19.
- If an individual is diagnosed with COVID-19, they must remain out of the program for a minimum of 7 days after the onset of first symptoms. They may return under the following conditions:
    - If they had a fever: 3 days after the fever ends without the use of fever-reducing medication AND there is improvement in their initial symptoms (e.g. cough, shortness of breath)
    - If they did not have a fever: 3 days after they see an improvement in their initial symptoms (e.g. cough, shortness of breath)

I, (family member name) _____, parent/guardian of,

_____, have read and agree to the above sick child policy amendment.

Family member signature: _____ Date: _____

Intake for Child Under 2 Years – Child Care Centers

Use of form: This form is mandatory for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for licensed family and group child care centers; however, it meets the requirements of DCF 250.09(1)(c)1. and 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)	Nickname (If any)	Birthdate (mm/dd/yyyy)
Name – Parent(s) (Last, First, MI)		Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH

Note: Health conditions that may affect the care of the child must be recorded in the child's health history record. The form should be shared with any person who provides care for the child.

☐ Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule

Length of time on current schedule

Food type

☐ Breast milk ☐ Formula ☐ Strained ☐ Junior ☐ Table ☐ Milk type – Specify:

New food timetable

When eating, child is

☐ Held in lap ☐ In highchair ☐ Other – Specify:

Feeds self

☐ Yes ☐ No If "Yes", uses: ☐ Spoon ☐ Fork ☐ Hands

Special feeding problems

☐ Yes ☐ No If "Yes" – Specify:

Food allergies

☐ Yes ☐ No If "Yes" – Specify:

Favorite foods – Specify

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule

Length of time on current schedule

Falls asleep easily

☐ Yes ☐ No

Mood upon awakening – Describe

Takes favorite toy(s) to bed – **child over age 1 year**

☐ Yes ☐ No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**

Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.

☐ Back for children under age 1 year ☐ Side or stomach (physician statement attached)

Sleep position – **child age 1 year and older**

☐ Back ☐ Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper type
☐ Cloth ☐ Disposable

Diapers provided by parent
☐ Yes ☐ No

Plastic pants used
☐ Always ☐ Never ☐ Sometimes If "Sometimes" – Specify:

Highly sensitive skin
☐ Yes ☐ No

Frequent diaper rash
☐ Yes ☐ No

Lotions, powders, or salves used
☐ Yes ☐ No If "Yes", product name(s) – Specify:

Toilet training attempted
☐ Yes ☐ No If "Yes", describe routine.

Type of toilet seat used at home
☐ Potty chair ☐ Special toilet seat ☐ Regular toilet seat

Regular bowel movements
☐ Yes ☐ No

How often

Time(s) of day

Toileting problems
☐ Yes ☐ No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family's spoken language.
☐ English ☐ Spanish ☐ Hmong ☐ Other If "Other" – Specify:

Age child began talking

Child speaks in
☐ Words ☐ Sentences

Words used to describe special needs – Specify

UPDATES

COMFORTING

Does child have a fussy time?
☐ Yes ☐ No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:
☐ Held ☐ Sung to ☐ Rocked ☐ Read to ☐ Other – Specify:

Special things you say or do to comfort child

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

☐ Sit up alone ☐ Pull up ☐ Crawl ☐ Walk holding on ☐ Walk without support

☐ Yes ☐ No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's favorite **indoor** toys and activities – Specify

Child's favorite **outdoor** toys and activities – Specify

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed