# Miss Amy's Home Daycare Enrollment Packet

# Personal Information Record for Infant/Toddler

Child's name _____ Age_____

What is your child's current daily sleeping schedule?

Morning wake-up time_____ Evening bedtime_____

Daily naps_____

Is your child sleeping thru the night? _____

If not when does the child usually wake up at night? _____

What upsets or frightens your child? _____

_____

What does your child find soothing or comfortable? _____

_____

How is your child now reacting to strangers? _____

_____

Is your child using a cup, a bottle or both? _____

Are you breastfeeding your child? _____ If yes at what times? _____

What are the times your child is now receiving the bottle each day? _____

_____

The number of ounces your child is now taking at each bottle feeding _____

Is your child taking formula, whole milk, skim milk or other? _____

Give any special instructions for preparing formula, if any_____

_____

Are there any other special instructions concerning bottle feeding your child?_____

_____

_____

_____

What are your child's favorite snacks? _____

Does he/she have a strong dislike for certain foods? _____

Are there any foods your child is not permitted to eat? _____

# Family Child Care Parent-Provider Agreement

**For Parents:**

My child _____ will begin to receive family child care
(Child's name)

services from _____ at _____
(Provider's name)

_____
(Address)

On _____ from _____ to _____
(Date) (Time) (Time)

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Other _____

The fee for service will be $_____ per _____ payable _____
week(s) in advance beginning on _____. Payment will be made every _____.

As a parent enrolling my child in family child care, I agree to:

- ❖ Inform the provider of my home and work address and telephone numbers.
- ❖ Arrange for a readily available person to pick up my child in the event I cannot be reached.
- ❖ Notify the provider if my child cannot be picked up or dropped off at the regular time.
- ❖ Inform the provider if someone other than parents will pick up my child.
- ❖ Give the provider an up-to-date immunization record and physician's examination statement for my child.
- ❖ Inform the provider if my child contracts a contagious disease.
- ❖ Pick up my child immediately if notified that he/she is ill.
- ❖ Maintain the following articles of clothing in the child care home at all times.

_____ _____ _____
_____ _____ _____

- ❖ Supply additional items listed below.

_____ _____ _____
_____ _____ _____

- ❖ I understand that a late fee of _____ per _____ payable on the next child care day, will be charged if I am late picking up my child.
- ❖ I also agree to the following:

_____
_____
_____
_____
_____

**For Providers**

As your child's family child care provider, I agree to:

- Discuss your child's daily activities and routines with you.
- Provide a safe, healthy, stimulating environment for your child.
- Inform you of the name of the substitute provider who will care for the children in my absence.
- Inform you about any pets in my home.
- Permit you to visit my home at any time when enrolled children are present.
- Inform you of my policy regarding the admission of sick children to my home and the administration of medication to children.
- Notify you immediately if your child is seriously injured, or by the end of the day, if the injury is not serious. I will give you a written accident report by the end of the next working day.
- Obtain your written permission before transporting your child.
- Obtain your written permission before permitting your school-age child to leave my direct supervision.
- Give you a copy of the Information to Parents Statement given to me by my sponsoring organization.
- Inform you that you may request the sponsoring organization to provide technical assistance or referral to appropriate community resources. My sponsoring organization is:

**Burlington County Community Action Program**
**718 Route 130 South**
**Burlington, NJ. 08016**

**Telephone: (609) 261-6834**

- I also agree to the following:

_____
_____
_____

My family child care will be closed for the following holidays:

_____ _____

_____ _____

_____ _____

Payment arrangements when my family child care program is closed:

_____

Payment arrangements when my family child care program is open and your child is absent:

_____

Signature of Parent(s) _____ Date _____
Signature of Parent(s) _____ Date _____
Signature of Parent(s) _____ Date _____
Signature of Provider _____ Date _____

# Child's Admission Records

Today's Date _____ Date of enrollment _____

**Child's name**_____ Date of Birth_____
Name by which child is most often called_____
Home address_____
Phone #_____

**Father's name**_____
Address_____
_____
Employed by _____ Telephone # _____
Address _____
Days & hours of employment _____

**Mother's name**_____
Address_____
_____
Employed by _____ Telephone # _____
Address_____
Days & hours of employment _____

**Person to contact in case of emergency if parents cannot be reached:**

Name _____ Telephone #_____
Name _____ Telephone #_____

Child's Doctor: Name_____ Telephone #_____
Doctor address _____

Child's Dentist: Name_____ Telephone #_____
Dentist address _____

For provider's use only: Date of withdrawal _____

# Family Information

Person(s) designated to pick up child other than parent(s):
Name _____ Telephone # _____

Name _____ Telephone # _____

Name any person(s) specifically not permitted to pick up your child:
Name _____ Relationship _____

Name _____ Relationship _____

Language (s) spoken in the home: _____

List other children in the family:
Name _____ Age _____ Sex_____

Name _____ Age _____ Sex_____

Name _____ Age _____ Sex_____

Name _____ Age _____ Sex_____

List other adults living in your home & their relationship to your child:
_____
_____

List pets in your child's home & their names: _____
_____

List previous experience in child care including name of facility, dates attended and type of care, (such as family childcare, childcare center, nursery school, nanny)
_____
_____

## Authorization for Transportation

I (name of parent) _____, will permit (name of provider) _____ to transport my child, (name of child) _____. Passenger restraint systems and possession of a valid driver's license and inspection sticker will be observed.

Signature _____

Date _____

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## Permission for Walks

(Local walks in your neighborhood only) (Not entering any establishments)

I (name of parent) _____, will permit (name if provider) _____ to escort my child, (name of child) _____, to (location) _____ on the following schedule _____. I understand that my child will be supervised by the provider at all times and will not be transported by motor vehicle.

Signature _____

Date _____

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## Authorization to Leave Premises

This is for a child going to a friend, or another activity, while in care

I (name of parent) _____ will permit (Name of child) _____ to leave the home of (name of provider) _____, for the following purpose (s): _____, on the following schedule: _____, _____, _____

Signature _____

Date _____

# Emergency Treatment Information and Authorization

I, (name of parent) _____, agree to the administration of emergency medical treatment to my child, (name of child) _____, by a duly qualified health practitioner in my absence.

I authorize (name of provider) _____ to arrange for such emergency medical treatment until such time as I can be present.

**Sign in the presence of notary.**

**Signature** _____

**Date** _____

**To be filled in by the notary public.**

Sworn and subscribed before me this _____ day of _____

Signature _____

What (if any) illness has your child had in the past month _____

_____

_____

Is your child now taking any type of medication? _____

Please list: _____

Is your child allergic to food, medicine, animals or anything else? _____

_____

List any chronic or handicapping problem your child has, such as seizures, asthma, diabetes, heart disease, and respiratory illness:

_____

_____

_____

_____

**Parent's hospitalization insurance or medical assistance plan:**

**Carrier:** _____

**Identification number:** _____

**Policy is in the name of** _____

# UNIVERSAL CHILD HEALTH RECORD

*Endorsed by:* *American Academy of Pediatrics, New Jersey Chapter*
*New Jersey Academy of Family Physicians*
*New Jersey Department of Health and Senior Services*

## SECTION I - TO BE COMPLETED BY PARENT(S)

| Child's Name *(Last)* *(First)* | Gender ☐ Male ☐ Female | Date of Birth / / |
|---|---|---|
| Does Child Have Health Insurance? ☐Yes ☐No | If Yes, Name of Child's Health Insurance Carrier | |
| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |
| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |

***I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.***

| Signature/Date | This form may be released to WIC. ☐Yes ☐No |
|---|---|

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

| Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No | |
|---|---|---|
| Abnormalities Noted: | Weight *(must be taken within 30 days for WIC)* | |
| | Height *(must be taken within 30 days for WIC)* | |
| | Head Circumference *(if <2 Years)* | |
| | Blood Pressure *(if ≥3 Years)* | |

| IMMUNIZATIONS | ☐ Immunization Record Attached<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ Special Care Plan Attached | Comments |

### PREVENTIVE HEALTH SCREENINGS

| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note If Abnormal |
|---|---|---|---|---|---|
| Hgb/Hct | | | Hearing | | |
| Lead: ☐ Capillary ☐ Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

| Name of Health Care Provider (Print) | Health Care Provider Stamp: |
|---|---|
| Signature/Date | |