Miss Amy's Home Daycare Enrollment Packet

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 _____

Personal Information Record for School Age Children

Child's name _____ **Age** _____

As a parent you can assist me in planning for your child's stay in my home by sharing the following information:

What are your child's favorite snacks? _____

Does your child dislike certain foods? _____

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

Do you wish to have your child complete homework assignments while in family child care?
_____

Would you prefer to balance some active play with completing homework assignments?
_____

Do you wish to have your child participate in any activities away from my home?
_____ If so please describe _____
_____

Describe arrangements for transporting your child, if any. (Please be aware that I require your written permission to allow your child to leave my direct supervision while in family child care.)
_____

State regulations require that television be used for program activities in the family child care home with discretion. I plan to allow a limited time for television viewing. Please share your recommendation for appropriate television programs for your child. _____
_____

Does your child have permission to phone his/her parent's place of business _____

How often? _____

What time (s) may child call? _____

Do these calls require a toll charge? _____ Will the family child care home be reimbursed for your child's telephone calls? _____

Do you wish to limit the number and length of phone calls your child makes and receives?
_____ If yes; please explain your limitations _____

Does your child have any hobbies or special interest? _____
_____

I will __or will not _____ be available for child care during school vacations or when your child is mildly ill.
Please use this space for additional comments _____
_____
_____
_____

School child attends _____
Grade _____ School telephone number _____
Parent(s) _____ Date _____
Parent(s) _____ Date _____
Provider _____ Date _____

MEDICAL DECLARATION STATEMENT FOR SCHOOL-AGE CHILD CARE

Child's Name: _____

Date of Birth: _____ Grade in September: _____

Is your child under any medical/physical restrictions? _____Yes _____No
If yes, check all that apply:

_____ Asthma
_____ Convulsions
_____ Diabetes
_____ Hearing Loss
_____ Other _____

Is your child taking any medication? _____ Yes _____ No
If yes, please list:

_____

Has your child been under a doctor's care or hospitalized within the last 3 years?
_____ Yes _____ No
If yes, please explain:

_____

_____

Is your child allergic to any medications/foods/insect stings? _____ Yes _____ No
If yes, please list:

_____

_____

Family Health Care Provider's Name: _____

Telephone Number: _____

Address: _____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, and may participate in all of the activities of the Family Child Care program, except as noted above.

Parent/Guardian 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 _____

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 _____

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 _____

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 _____

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)

_____
_____

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 _____

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:

_____
_____
_____
_____
_____

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 ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

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