

Welcome to the INFANT Class

Welcome to the Infant Room! We are excited to be a part of you and your infant's journey during this important first year. Our focus is on supporting your child's growth and development, with an emphasis on motor skills, language acquisition, and social-emotional milestones. Throughout the day, we engage your infant with a variety of enriching Montessori based activities, including music, story time, and large motor movements, all designed to foster development in a nurturing environment. We look forward to partnering with you in this exciting stage of your child's life.

What to bring for your infant

- ◆ Diapers (1-2 sleeves)
- ◆ Wipes (1-2 packs)
- ◆ Pacifier (if they take one)
- ◆ 3 changes of extra clothes
- ◆ Premade labeled bottles with lids – Provide 1 days-worth (more info in handbook)
- ◆ Baby food (if your infant is old enough)
- ◆ A sleep sack/swaddle for nap time
- ◆ Label all items you bring into the center

Please check daily that your infant's cubby is fully stocked. Our teachers will notify you if any items are running low.

For safety reasons: please DO NOT bring blankets or stuffed animals into center. We adhere to a strict policy of not placing any items in cribs with infants during nap time or having outside items such as backpacks at center.

Child Care Registration Form		Date child entered care	Date child left care
Child's name (Last, First, Middle)		Name used (Nickname)	Birthdate
Street address		City	Zip code
Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone # () -	home phone # () -	alternate phone # () -
Street address		City	Zip code
Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone # () -	home phone # () -	alternate phone # () -
<i>I give my permission for any of the following individuals to be contacted and my child may be released to any of them.</i> Parent/Guardian signature: _____ Date: _____			
In an emergency, if you are not able to contact me, contact the following:			
Name (first and last)	cell phone #	home phone #	alternative phone #
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
These individuals also have permission to pick up my child:			
Name (first and last)	cell phone #	home phone #	alternative phone #
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
	() -	() -	() -
Child's health information			
Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: _____ Phone: () - Street Address: _____		Child's last physical exam, if available	
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: _____ Phone: () - Street Address: _____		Child's last dental exam, if available	
Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)			

CHILD CARE AGREEMENT

First		Middle		Last				
Child's name:								
First		Middle		Last				
Parent or Guardian name:								
Days and times my child will receive care:								
Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday	
Arrival time								
Departure time								
FEE: \$ _____ per: ☐ Hour ☐ Day ☐ Week ☐ Month			Date payment due: Source of payment: ☐ Parent ☐ Other (specify): _____					
Overtime rate: \$ _____ per: _____			Late fee: \$ _____ per: _____					
I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated. I have read, understand and agree to comply with the policy and procedures and information for parents given to me by: Name of Licensee Around the Clock Childcare								
Parent or guardian signature			Date		Parent or guardian signature			Date
I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.								
Licensee signature						Date		
Street Address		City		State		Zip code		
Comments								

Child and Adult Care Food Program (CACFP) Enrollment Income Eligibility Application (EIEA)

PART 1 – CHILDREN’S INFORMATION (REQUIRED)										
Child’s Name	Birthdate	Age	Days of Attendance	Arrival Time	Departure Time	Circle Meals and Snacks Normally Received			Check Below if Foster Child	
			Sun Mon Tu Wed Th Fri Sat			Breakfast	A.M. Snack	Lunch	☐	
			Sun Mon Tu Wed Th Fri Sat			P.M. Snack	Supper	Eve. Snack	☐	
			Sun Mon Tu Wed Th Fri Sat			Breakfast	A.M. Snack	Lunch	☐	
			Sun Mon Tu Wed Th Fri Sat			P.M. Snack	Supper	Eve. Snack	☐	
			Sun Mon Tu Wed Th Fri Sat			Breakfast	A.M. Snack	Lunch	☐	
			Sun Mon Tu Wed Th Fri Sat			P.M. Snack	Supper	Eve. Snack	☐	
PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR IN WA STATE - Any household member receiving benefits can establish eligibility for children in the household. If listing case number or ID, please skip to part 5.								Case Number or ID number		
PART 3 – TOTAL HOUSEHOLD GROSS ANNUAL INCOME						PART 4 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)				
The adult signing the form must list the last four digits of their Social Security Number (SSN) or check the box if no SSN. See Privacy Act Statement and Sources of Income on the back of this page (Annual Income Conversion by pay frequency: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12)						We are required to ask for information about your children’s race and ethnicity. This information helps to make sure we are fully serving our community. Responding to this section is optional, it will not affect your children’s eligibility for receiving meals during care. Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race (check one or more): ☐ American Indian or Alaskan Native ☐ Multi-Racial ☐ Native Hawaiian or Pacific Island ☐ Black or African American ☐ Asian ☐ White				
List names (First and Last) of everyone in your household, including foster children	Annual Earnings from Work Before Deductions	Annual Welfare, Alimony, Child Support	Retirement, Pensions, Social Security, Other	Total						
1.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
2.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
3.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
4.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
5.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
6.	\$ /yr	\$ /yr	\$ /yr	\$ /yr						
Number of Household Members		Last 4 of SSN (check box if no SSN)			☐	☐	☐	☐	☐	
PART 5 – PARENT/GUARDIAN SIGNATURE AND CERTIFICATION—(REQUIRED) SIGNATURE CONFIRMS ALL INFORMATION PROVIDED IS CORRECT AND ACCURATE										
"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."										
Signature _____			Print Name _____			Date _____				
Address _____			City, State, Zip _____			Phone Number _____				
DO NOT FILL OUT – CENTER USE ONLY				CATEGORY			OSPI USE ONLY			
_____ Institution Representative Signature _____ Date INVALID WITHOUT SIGNATURE AND DATE (see back for effective date requirements)				☐ Free (Basic Food/TANF/FDPIR) ☐ Free (foster child(ren))			Total Annual Income \$ _____ ☐ Free ☐ Reduced-Price ☐ Above-Scale			
							☐ Free ☐ Reduced ☐ AS _____ OSPI Rep.			

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

FAX: (833) 256-1665 or (202) 690-7442; or

EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

EIEA Effective Date

If the institution uses the parent/guardian signature date as the effective date, the form must be signed by the institution representative within the same month as the parent, or the following month. If the institution representative does not sign the EIEA within these timeframes, the institution representative's signature date must be used as the effective date.

Valid TANF or Basic Food Number Guidelines and Contact Resources for WA State Recipients

Consists of seven to nine digits, such as 004235555 A parent may omit the zeros preceding the number and write as (ex. 4235555) May start with 002, 003, 004, 005 or 05 Does not include any letters	Is not a social security number (unless it's a tribal case number). Does not start with a 200 series number Is not a case number for state-paid childcare Is not an EBT card number
---	--

DSHS Customer Service Number: (877) 501-2233

Basic Food and TANF website: www.washingtonconnection.org

Earnings from Work	Public Assistance, Alimony, Child Support	Pension, Retirement, Other Sources of Income	Sources of Child Income	Examples:
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) <u>If you are in the U.S. Military:</u> - Basic pay and cash bonuses (does NOT include combat pay, FSSA, or privatized housing allowances) - Allowances for off-base housing, food, and clothing	- Unemployment benefits - Workers' compensation - Supplemental Security Income - Cash assistance from State or local government - Alimony payments - Child support payments - Veterans benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private Pensions or disability benefits - Income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household	Earnings from work Social Security -Disability Payments -Survivors Benefits Income from any other source	A child of legal working age has a regular full or part-time job where they earn a salary or wages - A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits A child receives regular income from a private pension fund, annuity, or trust

Health & Development Information Form + Special Needs/Behavioral Policy

To be completed by parent/guardian prior to enrollment. All information is confidential and used to ensure the safety and success of your child.

Child Information

Child's Full Name: _____

Date of Birth: _____

Primary Language Spoken at Home: _____

Medical History & General Health (per WAC 110-300-0500)

1. Diagnosed medical conditions (e.g., asthma, allergies, seizures)?

☐ No ☐ Yes – Please explain: _____

2. Regular medications?

☐ No ☐ Yes – Please explain: _____

3. Food allergies or dietary restrictions?

☐ No ☐ Yes – Please explain: _____

4. Hospitalizations or surgeries?

☐ No ☐ Yes – Please explain: _____

Developmental & Behavioral Needs

As part of our commitment to inclusive care, we ask families to disclose any developmental, behavioral, or medical needs that may affect day-to-day care, safety, or learning. This includes conditions that may require support such as 1:1 supervision, sensory accommodations, or behavioral strategies.

Examples of challenges include, but are not limited to:

- ADHD
- Autism Spectrum Disorder
- Anxiety or emotional dysregulation
- Oppositional Defiant Disorder (ODD) or Explosive Disorder

- Speech or language delays
- Sensory processing challenges
- Social-emotional delays

1. Has your child ever been diagnosed with or evaluated for any of the above or similar needs?

☐ No ☐ Yes – Please describe (diagnosis, services received, etc.):

2. Current support services (Check all that apply):

☐ Speech therapy ☐ Occupational therapy ☐ Behavioral therapy
☐ ABA services ☐ IEP/IFSP in place ☐ Other: _____

3. Does your child require any of the following during their day?

☐ One-on-one assistance for safety, redirection, or participation
☐ Frequent breaks or a quiet space to regulate
☐ Supervision during transitions (e.g., walking to class, lining up, playground)
☐ Help with toileting or personal care
☐ Additional support for group activities or circle time
☐ None of the above

4. Has your child consistently displayed any of these behaviors? (Check all that apply):

☐ Wandering or running away from group
☐ Difficulty participating in group activities
☐ Aggression (hitting, biting, pushing, etc.)
☐ Self-injury (head-banging, biting self, etc.)
☐ Extreme resistance to transitions
☐ Other: _____

5. What strategies have worked at home or in other programs to support your child's behavior?

Policy Summary: Support for Children with Special Needs or Behavioral Concerns

At Around The Clock Child Care, we welcome all children and aim to create a nurturing, safe, and inclusive environment. While we are not a licensed ECEAP or special education provider, we strive to support children's diverse needs within the scope of our program and staffing.

If your child has known or suspected special needs, we may request:

- A current health or behavioral care plan
- Documentation from therapists or medical providers
- A developmental assessment (IEP/IFSP, etc.)
- A family meeting to determine the best approach

Please understand:

- We are not staffed for permanent 1:1 aides or specialized services.
- Accommodations must not cause safety risks or undue hardship to the program.
- In rare cases, enrollment may be delayed, limited, or declined if needs exceed our capacity, in accordance with WAC 110-300-0505.

Parent/Guardian Acknowledgment

I understand that Around The Clock Child Care is not a designated special education provider and may not have the capacity for high-needs individualized support. I confirm that I have disclosed all relevant information to the best of my knowledge and understand that additional evaluation or support may be needed before or during enrollment.

Parent/Guardian Signature: _____

Date: _____

INFANT PERSONAL CARE PLAN DEVELOPMENTAL HISTORY FORM



Today's Date: _____ Date of Enrollment/Transition: _____
 Child's Name: _____ Date of Birth: _____ Age: _____
 Date of Last Physical (for WA State only): _____
 What would you like us to call your child?: _____
 Parent/Guardian Name: _____
 Parent/Guardian Name: _____
 Name of Person Completing Form: _____
 Primary Caregiver: _____
 Classroom: _____

FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

Name	How child addresses this individual?	Age

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

I'll take good care of you	
I see that you are crying	
Let's change your diaper	
I like your smile	
It's time for your bottle	
Time to eat	
Time for your nap	
Mommy will be back	
Daddy will be back	

If parental custody is shared, describe the custody arrangements: _____

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home: _____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

DEVELOPMENTAL HISTORY

Age Child Began: Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words: _____ Saying 2 or 3 simple sentences: _____

Do you have developmental concerns about your child? _____

How does your child communicate his/her needs? _____

CHILD'S HEALTH

List medications regularly taken and conditions requiring them: _____

Describe serious illnesses or hospitalizations: _____

Describe special physical conditions, disabilities, allergies, or concerns: _____

Does your child have a special need? _____

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): _____

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

NUTRITION PRACTICES AND ROUTINES

How is your child fed? Check all that apply: Breast: ☐ Bottle: ☐ Cup: ☐

In the corresponding row, provide your child's feeding details.

	Brand	Amount	Preferred time of day given
Formula/Milk			
Breast Milk			
Juice			

If your baby is exclusively breast fed, please outline your daily plan: _____

If your baby is breast fed or receiving expressed breast milk, how can we support you? _____

List special dietary requests, and restrictions: _____

Have solid foods been introduced? Yes ☐ No ☐ If yes, please identify: _____

Food likes and eating preferences: _____

Child Eats With: Spoon: ☐ Fork: ☐ Fingers: ☐

Child is Fed in: Highchair: ☐ In Arms: ☐ Bouncy Seat: ☐ Other: _____

Preferred time of day to feed child: ☐ A.M. ☐ A.M. ☐ P.M. ☐ P.M.

Additional Information: _____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

SLEEPING ROUTINES

Pre-nap routines/rituals: _____

Number of naps daily: ____ From: ____ To: ____ From: ____ To: ____ From: ____ To: ____

Preferred sleep position*: _____

At home child sleeps in (Check all that apply: Bassinet: ☐ Crib: ☐ Bed: ☐

Child's typical waking behavior/routine: _____

Special sleeping concerns: _____

Note: Bright Horizons places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than on his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime.

COMFORTING CHILD

Position child prefers to be held: _____

Security object (if any): _____ Name child uses for object/when needed: _____

Does your child use a pacifier? Yes ☐ No ☐ If yes, when: _____

Describe how adults can comfort your child? _____

DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: disposable: ☐ cloth: ☐

Words used for urination: _____

Words used for bowel movement: _____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

SOCIAL RELATIONSHIPS

Has your child had any experience with group care? If yes, please describe: _____

How does your child react to new situations and new children and adults? _____

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations? _____

Child's favorite toys and activities: _____

Does your child have any fears? Explain: _____

ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy: _____

Is there additional information you feel is important for the staff to know about your child or family? _____

What do you as a family, hope to get out of this child care experience? _____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	



Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:

Reviewed by:

Date:

Signed Cert. of Exemption on file? ☐ Yes ☐ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YY):	Sex:
I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record. ➔			I certify that the information provided on this form is correct and verifiable. ➔	
Parent/Guardian Signature Required			Date	
Parent/Guardian Signature Required			Date	

◆ Required for School and Child Care/Preschool

● Required Only for Child Care/Preschool

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Required Vaccines for School or Child Care Entry

◆ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)

◆ **Tdap** (Tetanus, Diphtheria, Pertussis)

◆ **Td** (Tetanus, Diphtheria)

◆ **Hepatitis B**

☐ 2-dose schedule used between ages 11-15

● **Hib** (*Haemophilus influenzae* type b)

◆ **IPV / OPV** (Polio)

◆ **MMR** (Measles, Mumps, Rubella)

● **PCV / PPSV** (Pneumococcal)

◆ **Varicella** (Chickenpox)

☐ History of disease verified by IIS

Recommended Vaccines (Not Required for School or Child Care Entry)

Flu (Influenza)

Hepatitis A

HPV (Human Papillomavirus)

MCV, MPSV (Meningococcal)

MenB (Meningococcal)

Rotavirus

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of **Varicella (Chickenpox)** or can show immunity by blood test (titer) it **MUST** be verified by a healthcare provider

I certify that the child named on this CIS has:

☐ a verified history of Varicella (Chickenpox).

☐ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

☐ Diphtheria

☐ Hepatitis A

☐ Hepatitis B

☐ Hib

☐ Measles

☐ Mumps

☐ Polio

☐ Rubella

☐ Tetanus

☐ Varicella

☐ Other:

Licensed healthcare provider signature Date
(MD, DO, ND, PA, ARNP)

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at <https://wa.myir.net>. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements.**

☐ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.

☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS.**

Reference guide for vaccine abbreviations in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

Consent to medical care and treatment of minor children

I give permission that my child, _____ may be given
first aid/emergency treatment by the child care licensee and or qualified staff at:

Name of Licensee: _____

Address of Licensee: _____

Parent/guardian signature	Date	Parent/guardian signature	Date
---------------------------	------	---------------------------	------

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date
---------------------------	------	---------------------------	------

Individual Care Plan for Child in Child Care

Plan must be updated annually or when there is a change in the child's special need

FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS

This page must be completed and signed by the child's health care provider and parent or guardian.

Child's Full Name:		Today's Date:
Food the child must not consume (list each food separately)	Appropriate substitute food(s)	
Describe allergic reactions and symptoms associated with this child's particular allergies.		
Describe the treatment plan for the early learning provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication).		
Other special dietary requirements due to a health condition.		

Health Care Provider Signature

Date

Parent or Guardian Signature

Date

Authorization for Emergency Care Of Children with Severe Allergies

This information pertains to the 20____ - 20____ academic year.

Dear Health Care Provider,

Your patient, _____ is enrolled in Around the clock Childcare Center Inc and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at Around the clock Childcare Center Inc so we may assist with the allergy care and needs of the child. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at Around the clock Childcare Center Inc

PART I (to be completed by a Licensed Health Care Provider)

Child's Name: _____ Child's Birth Date: _____

Known Allergens: (Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e. Anaphylactic shock) in the child.)

_____ Bee Sting

_____ Other Insect Bite(s): (identify): _____

_____ Animal(s): (identify): _____

_____ Food Allergy: (identify all foods or groups of foods that must be avoided): _____

_____ Other: (identify): _____

SYMPTOMS: (Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.)

_____ Shortness of Breath _____ Swelling of the Face or Lips _____ Diarrhea

_____ Hives _____ Vomiting

_____ Other: (explain): _____

Signature of Authorized Personell _____

Date _____

Child Care Medication Authorization Form

An early learning provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate cleaned and sanitized medication measuring devices. WAC 110-300-0215

Child's full name (first and last):		Child's Birthdate:
Name of Medication (as it appears on medication container):		
Dosage:	Start Date:	End Date:
To be given at the following times:		
Reason for Giving Medication to Child/Medical Need:		
Possible Side Effects of Medication:		
Additional Information:		

Prescription medication must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name, the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

Nonprescription (over-the-counter) medication must be brought to the early learning program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

I hereby give permission for the staff of _____ to give my child the medication as prescribed above.
(name of early learning provider/program)

Parent/Guardian Signature

Date

This section to be completed by child's parent or guardian, if applicable:

I, or my appointed designee, have provided training about specialized medication administration procedures for my child specific to this medication to the following staff member(s): _____

Parent/Guardian (or Designee) Signature Date

Early Learning Provider Signature Date

NON-PRESCRIPTION MEDICATION FORM

Child's Name _____

I hereby give permission to _____

to administer the over-the-counter preparations listed below in accordance with the directions for use listed on the container.

Specify name brand, frequency, and duration of use.

Baby Wipes _____

Ointment (Desitin, Vaseline, etc.) _____

Baby Powder _____

Sunscreen _____

Insect Repellent _____

Other _____

* I release the above named daycare provider from any liability from administering these products.

Parent Signature/Date _____

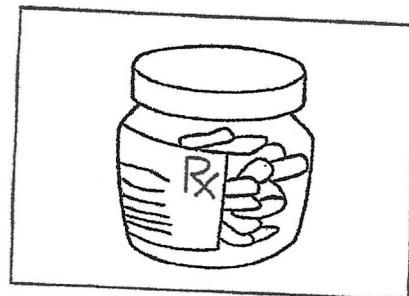
Parent Signature/Date _____

All items must be supplied by parents if use is requested. All items must be provided in the original container clearly labeled with the child's name.

Prescription Medication Log

Child's Name _____

Date _____



I give permission to my child care provider, _____, to administer the following medication to my child. I will not hold my provider liable in the event of reactions or complications arising from my child receiving this medication.

Parent Signature _____

Name of medication: _____

Reason for medication: _____

Start Date _____ Finish Date _____

Times for each dosage: _____ am or pm _____ am or pm

Amount per dose: _____

[illegible]

Individual Care Plan for Child in Child Care

Plan must be updated annually or when there is a change in the child's special need

Child's Full Name	Today's Date
CONTACT INFORMATION	
Parent's/Guardian's Name	Telephone
Parent's/Guardian's Name	Telephone
Primary Health Care Provider	Telephone
Specialist (if applicable)	Telephone
Specialist (if applicable)	Telephone
CHILD'S SPECIAL NEEDS	
Diagnosis, if known:	
Known symptoms and triggers:	
Describe activity, behavioral, or environmental modifications that are needed for the child:	
Allergies (other than food allergy):	
For food allergies or special dietary needs due to a health condition - must obtain written instructions from child's health care provider (use page 3 of this form or health care provider's form)	
MEDICATIONS <i>(Medication Authorization Form must be completed for each medication.)</i>	
List medication to be given at scheduled times , and how medication is to be given.	
List medication to be given during an emergency , and how medication is to be given.	
Describe symptoms that would trigger emergency medication.	

Individual Care Plan for Child in Child Care

Plan must be updated annually or when there is a change in the child's special need

EMERGENCY RESPONSE PLAN

List the steps and procedures the early learning provider should perform during an emergency related to your child's special need.

SUGGESTED TRAINING FOR STAFF

List suggested special skills training/education for the early learning program staff.

SUPPORTING DOCUMENTATION

Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 requires an early learning provider to have supporting documentation of the child's special needs provided by the child's licensed or certified:

- (i) Physician or physician's assistant
- (ii) Mental health professional
- (iii) Educational professional
- (iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or
- (v) Registered nurse or advanced registered nurse practitioner.

SIGNATURES

Parent or Guardian Signature

Date

Early Learning Provider Signature

Date

Health Care Provider Signature
(recommended)

Date

This section to be completed by child's parent or guardian, if applicable:

*I hereby give permission for _____ to provide
(name of visiting health professional or specialist)
services to my child at this early learning program.*

Parent or Guardian Signature

Date

Emergency Contact Form

Name: _____

Department: _____ Date: _____

Home Information:

In case of emergencies due to weather conditions:

Home Address: _____

Home Phone: _____

Cellular Telephone: _____

Personal Email Address: _____

Primary Emergency Contact

Contact Name: _____

Relationship to Contact: _____

Home Telephone: _____

Work Telephone: _____ Cellular Telephone: _____

Email: _____

Secondary Emergency Contact

Contact Name: _____

Relationship to Contact: _____

Home Telephone: _____

Work Telephone: _____ Cellular Telephone: _____

Email: _____

Additional Information (Voluntary)

Allergies (Food, Medication, Insects, Etc.): _____

Medical Alert(s): _____



Child Care Parent/Guardian Permission

Child's Name (First Middle Last)	Licensee's Name																																																			
Transportation and off-site activity I give my permission for the licensee or the licensee's staff to take my child: <table style="width: 100%;"><thead><tr><th></th><th style="text-align: center;"><u>Yes</u></th><th style="text-align: center;"><u>No</u></th></tr></thead><tbody><tr><td>To and/or from school:</td><td></td><td></td></tr><tr><td> By a personal vehicle.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By riding with my child on public transportation.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By walking with my child</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td>On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken):</td><td></td><td></td></tr><tr><td> By a personal vehicle.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By riding with my child on public transportation.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By walking with my child</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td>On occasional errands:</td><td></td><td></td></tr><tr><td> By a personal vehicle.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By riding with my child on public transportation.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By walking with my child</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td>Other (specify here: _____):</td><td></td><td></td></tr><tr><td> By a personal vehicle.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By riding with my child on public transportation.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td> By walking with my child</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr></tbody></table>			<u>Yes</u>	<u>No</u>	To and/or from school:			By a personal vehicle.....	☐	☐	By riding with my child on public transportation.....	☐	☐	By walking with my child	☐	☐	On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken):			By a personal vehicle.....	☐	☐	By riding with my child on public transportation.....	☐	☐	By walking with my child	☐	☐	On occasional errands:			By a personal vehicle.....	☐	☐	By riding with my child on public transportation.....	☐	☐	By walking with my child	☐	☐	Other (specify here: _____):			By a personal vehicle.....	☐	☐	By riding with my child on public transportation.....	☐	☐	By walking with my child	☐	☐
	<u>Yes</u>	<u>No</u>																																																		
To and/or from school:																																																				
By a personal vehicle.....	☐	☐																																																		
By riding with my child on public transportation.....	☐	☐																																																		
By walking with my child	☐	☐																																																		
On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken):																																																				
By a personal vehicle.....	☐	☐																																																		
By riding with my child on public transportation.....	☐	☐																																																		
By walking with my child	☐	☐																																																		
On occasional errands:																																																				
By a personal vehicle.....	☐	☐																																																		
By riding with my child on public transportation.....	☐	☐																																																		
By walking with my child	☐	☐																																																		
Other (specify here: _____):																																																				
By a personal vehicle.....	☐	☐																																																		
By riding with my child on public transportation.....	☐	☐																																																		
By walking with my child	☐	☐																																																		
Water activities including swimming pools and other bodies of water I give my permission for the licensee or the licensee's staff to: <table style="width: 100%;"><thead><tr><th></th><th style="text-align: center;"><u>Yes</u></th><th style="text-align: center;"><u>No</u></th></tr></thead><tbody><tr><td>Take my child swimming or play in a swimming pool or other body of water</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr></tbody></table>			<u>Yes</u>	<u>No</u>	Take my child swimming or play in a swimming pool or other body of water	☐	☐																																													
	<u>Yes</u>	<u>No</u>																																																		
Take my child swimming or play in a swimming pool or other body of water	☐	☐																																																		
Bathing I give my permission for the licensee or the licensee's staff to: <table style="width: 100%;"><thead><tr><th></th><th style="text-align: center;"><u>Yes</u></th><th style="text-align: center;"><u>No</u></th></tr></thead><tbody><tr><td>Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting.....</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr><tr><td>Give my child a bath or shower if my child is enrolled in overnight child care</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr></tbody></table>			<u>Yes</u>	<u>No</u>	Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting.....	☐	☐	Give my child a bath or shower if my child is enrolled in overnight child care	☐	☐																																										
	<u>Yes</u>	<u>No</u>																																																		
Give my child a bath or shower if my child needs to be cleaned after having an accident such as diarrhea or vomiting.....	☐	☐																																																		
Give my child a bath or shower if my child is enrolled in overnight child care	☐	☐																																																		

Photo, video, or surveillance activity

I give my permission for the licensee or the licensee's staff to:

	<u>Yes</u>	<u>No</u>
Take photographs of my child	☒	☐
Take video of my child.....	☒	☐
Capture my child's image on surveillance video used at this child care facility	☒	☐

I have reviewed the licensee's written policies and have had the opportunity to discuss with the licensee the policies pertaining to the items listed on this permission form.

Parent or guardian signature

Date

Parent or guardian signature

Date



Permission to Photograph

I, _____, give permission for _____ to
(Parent or Guardian name) (Child Care Provider)
 photograph my child, _____, for the following purposes:
(Child's name)

Type of Use:	(Please check one)	
	Grant Permission	Decline Permission
Still Photographs:		
Display in my personal scrapbook	☐	☐
Give photographs possibly containing your child to current clients	☐	☐
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients	☐	☐
Display still photos on child care website*	☐	☐
Post photos on child care's Facebook page	☐	☐
Other:	☐	☐
Videos:		
Give video to current parents	☐	☐
YouTube™ promotional video	☐	☐
Other:	☐	☐
Other (please list):		
	☐	☐
	☐	☐
	☐	☐
	☐	☐

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

 (Parent or Guardian signature)

 (Date)

Acknowledgment of Handbook Receipt and Agreement

I acknowledge that I have received a copy of the **Parent Handbook** for Around the Clock Childcare Center of Learning and Development, either in digital format or a paper copy upon my request.

I understand and agree to abide by the policies and procedures outlined in the handbook, including but not limited to the following:

- **Health and Safety Policies**
- **Attendance and Absence Policies**
- **Communication Guidelines**
- **Field Trip and Activity Permissions**
- **Emergency Procedures**
- **Disciplinary Actions and Behavioral Expectations**
- **Fee and Payment Policies**
- **Photo Release and Privacy Policies**
- **Program Descriptions**
- **Daily Schedules and Routines**
- **Nutrition and Snack Policies**
- **Medication Administration**
- **Parent and Family Involvement**
- **Complaint and Grievance Procedures**
- **Confidentiality and Privacy Practices**
- **Drop-off and Pick-up Procedures**
- **Inclement Weather and Closure Policies**
- **Behavior Management Strategies**
- **Staff Qualifications and Training**
- **Arbitration Agreement**

I understand that these policies are in place to ensure a safe, healthy, and effective learning environment for all children enrolled at the center. I agree to follow these guidelines and to support the staff in their efforts to provide the best care and education for my child.

I also understand and agree to the **Arbitration Agreement** included in the handbook, which requires that any disputes arising out of or relating to my child's enrollment at the center be resolved through binding arbitration rather than in court.

By signing below, I confirm that I have read and understood all verbiage and policies detailed in the Parent Handbook. I acknowledge that I am responsible for adhering to all policies and procedures as stated.

Parent/Guardian Name: _____

Child's Name: _____

Date: _____

Signature: _____