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 give my permission for any of the following individuals to be contacted and my child may be released to any of them.

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

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 P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack	☐
			Sun Mon Tu Wed Th Fri Sat			Breakfast A.M. Snack Lunch 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

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)

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
1.	$ /yr	$ /yr	$ /yr
2.	$ /yr	$ /yr	$ /yr
3.	$ /yr	$ /yr	$ /yr
4.	$ /yr	$ /yr	$ /yr
5.	$ /yr	$ /yr	$ /yr
6.	$ /yr	$ /yr	$ /yr

Number of Household Members		Last 4 of SSN (check box if no SSN)				

PART 4 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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

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) If you are in the U.S. Military: • 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	A child of legal working age has a regular full or part-time job where they earn a salary or wages
			Social Security -Disability Payments -Survivors Benefits	• 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
			Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

Toddler/Twos 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?: .....

What languages are spoken at home? .....

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 words used in your language corresponding to the English below. 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	
Time to eat	
Everyone is napping now	
Mommy will be back	
Daddy will be back	
Time to use the bathroom	
Now we wash our hands	

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:

.....

.....

.....

Toddler/Twos Personal Care Plan: DEVELOPMENTAL HISTORY FORM

Child's Name: .....

DEVELOPMENTAL HISTORY

Does your child: Crawl? Yes ☐ No ☐ Walk with support ? Yes ☐ No ☐ Walk without support? Yes ☐ No ☐

Does your child: Say audible words? Yes ☐ No ☐ Speak in 2 or 3 audible sentences? Yes ☐ No ☐

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.

Toddler/Twos Personal Care Plan: DEVELOPMENTAL HISTORY FORM

Child's Name: .....

NUTRITION PRACTICES AND ROUTINES

List special dietary requests, and restrictions: .....

.....

.....

.....

Food likes and eating preferences: .....

.....

.....

.....

Child eats with: Spoon ☐ Fork ☐ Fingers ☐ Other ☐ .....

Child is fed in: In highchair ☐ At the table ☐ Other ☐ .....

Additional Information: .....

.....

.....

.....

SLEEPING ROUTINES

Pre-nap routines/rituals: .....

.....

.....

.....

Number of naps daily: From: ..... To: ..... From: ..... To: .....

What time does your child go to bed at night? ..... Wake in morning? .....

At home child sleeps in (Check all that apply): Crib ☐ Bed ☐ With parents ☐

Child's typical waking behavior/routine/mood: .....

.....

.....

.....

Special sleeping concerns: .....

.....

.....

.....

Toddler/Twos Personal Care Plan: DEVELOPMENTAL HISTORY FORM

Child's Name: .....

DIAPERING/TOILETING ROUTINES

Is your child toilet trained? Yes ☐ No ☐ Urination ☐ Bowels ☐ Both ☐ If yes, when did you begin? .....

Does your child have accidents? Yes ☐ No ☐ If yes, how often/when? .....

Does your child wear diapers during the day? Yes ☐ No ☐

Does your child wear diapers when napping? Yes ☐ No ☐

If yes, what type you will provide? Disposable ☐ Cloth ☐

Words used for urination: .....

.....

.....

Words used for bowel movement: .....

.....

.....

Are bowel movements regular? Yes ☐ No ☐ How often/when? .....

.....

Is there a problem with: Diarrhea ☐ Constipation ☐ Explain: .....

.....

.....

What is used at home for toileting? Potty chair ☐ Special seat ☐ Regular seat ☐ Explain: .....

.....

.....

How can we support toilet learning? .....

.....

.....

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? .....

.....

.....

.....

Toddler/Twos Personal Care Plan: DEVELOPMENTAL HISTORY FORM

Child's Name: .....

SOCIAL RELATIONSHIPS

Has your child had any experience with group care? Yes ☐ No ☐ If yes, please describe: .....

.....

.....

Is your child: Friendly ☐ Aggressive ☐ Shy ☐ Withdrawn ☐ Explain: .....

.....

.....

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

.....

.....

Does your child prefer to play: Alone ☐ In small groups ☐ Explain: .....

.....

.....

Has your child had previous child care experience? Yes ☐ No ☐ If yes, explain how it met, or did not meet, your expectations?

.....

.....

Child's favorite toys and activities: .....

.....

.....

Does your child have any fears? Yes ☐ No ☐ If yes, please 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? .....

.....

.....

Toddler/Twos 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.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

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	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

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

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: waiisrecords@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	*Haemophilus influenzae* 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 tames 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		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

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.

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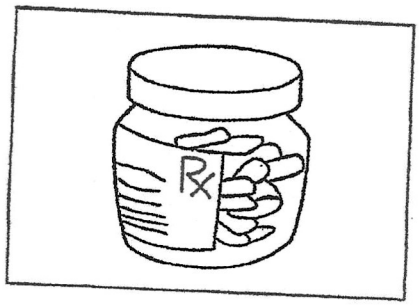
Prescription Medication Log



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: _____

Dosage Log				
Date	Time	Dose	Signature	Comments

Washington State Department of CHILDREN, YOUTH & FAMILIES

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:

	Yes	No
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:

	Yes	No
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:

	Yes	No
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:

	Yes	No
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)

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):_____

_____

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 ***(Medication Authorization Form must be completed for each medication.)***	
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 Date *(recommended)*

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

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: _____