

# CHILDREN'S ENROLLMENT FORM

Entrance Date \_\_\_\_\_ Withdrawal Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Father's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Living Arrangements: (check one)  Both Parents  Mother  Father  Other

Child's Legal Guardian(s): (check one)  Both Parents  Mother  Father  Other

The child may be released to the person(s) signing this agreement or to the following:

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)

Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_

Relationship to Parent(s) or Guardian \_\_\_\_\_

Other identifying information (if any) \_\_\_\_\_

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)

Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_

Relationship to Parent(s) or Guardian \_\_\_\_\_

Other identifying information (if any) \_\_\_\_\_

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name of Public or Private School child attends, if any: \_\_\_\_\_

Child's doctor or clinic name \_\_\_\_\_

Doctor/clinic phone # \_\_\_\_\_

My child has the following special needs \_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: \_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: \_\_\_\_\_

## EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_  
suffer an injury or illness while in the care of (Facility name) \_\_\_\_\_  
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention  
and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: \_\_\_\_\_

Signature

Date: \_\_\_\_\_

Facility Administrator/Person-In-Charge \_\_\_\_\_

Signature

Date: \_\_\_\_\_

## Parental Agreements with Child Care Facility

The \_\_\_\_\_ agrees to provide child care for  
 \_\_\_\_\_  
 (Name of Facility)  
 \_\_\_\_\_ on \_\_\_\_\_ a.m. to \_\_\_\_\_ p.m.  
 (Name of Child) (Days of Week)  
 from \_\_\_\_\_ to \_\_\_\_\_  
 (Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Evening Snack
- Dinner
- Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The \_\_\_\_\_ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for

\_\_\_\_\_  
 (Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent/Guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Facility Administrator/Person-In-Charge)

# Safe Sleep Practices Policy

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Safe Sleep Practices/Policies: \_\_\_\_\_

1. Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame during which the instructions are to be followed.
2. Cribs shall be in compliance with the Consumer Product Safety Commission (CPSC) and American Society of Testing and Materials International (ASTM) safety standards. They will be maintained in good repair and free from hazards.
3. No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
4. No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors, and mobiles.
5. Only sleepers, sleep sacks, and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.
6. Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots and mats will be laundered daily or marked for individual use. If marked for individual use, the sheets or covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice: \_\_\_\_\_.
7. Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will be moved to a safety-approved crib for sleeping.
8. Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
9. Wedges, other infant positioning devices, and monitors will not be permitted unless a physician's written statement authorizing their use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.
10. I acknowledge that the Director or designee has advised me of the facility's safe sleep practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Medication Authorization

Child's Full Name \_\_\_\_\_

Name of Medication \_\_\_\_\_

Prescription Number \_\_\_\_\_

Time Medication is to be Given \_\_\_\_\_

Amount of Medication to be Given \_\_\_\_\_

Date(s) to be Given \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

## For Center Use

Date	Time Given	Amount	Adverse Reactions	Administered By

If there was noticeable adverse reaction to medication, what action was taken? Describe below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# INFANT FEEDING PLAN

Child's Full Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Does the child take a bottle? Yes [ ] No [ ]  
Is the bottle warmed? Yes [ ] No [ ]  
Does the child hold own bottle? Yes [ ] No [ ]  
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (check all that apply)

Strained Foods [ ] Whole Milk [ ]  
Baby Foods [ ] Table Food [ ]  
Formula [ ] Other [ ]

What type formula used, if applicable? \_\_\_\_\_

Amount and time of formula/breast milk to be given? \_\_\_\_\_ Date \_\_\_\_\_

## UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN

DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? \_\_\_\_\_

## INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: \_\_\_\_\_

The child has reached the following developmental skills:

Can hold his/her head steady? Yes [ ] No [ ]  
Opens mouth/leans forward in anticipation of food offered? Yes [ ] No [ ]  
Closes lips around a spoon? Yes [ ] No [ ]  
Transfers food from front of the tongue to the back and swallows? Yes [ ] No [ ]

Instructions for the introduction of solid foods \_\_\_\_\_

Food likes \_\_\_\_\_

Food dislikes \_\_\_\_\_

Allergies? (including any premixed formula) \_\_\_\_\_

## UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN

TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. \_\_\_\_\_

PARENT'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

# Infant Affidavit

Name of Sponsor (if applicable) \_\_\_\_\_

Name of Provider/Center \_\_\_\_\_

Name of Infant: \_\_\_\_\_

Infant Date of Birth: \_\_\_\_\_

Name of Parent/Guardian:

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: \_\_\_\_\_

Center/provider will provide the following Iron-fortified infant cereal: \_\_\_\_\_

Center/provider will provide the following brand of infant foods: \_\_\_\_\_

Parents/Guardians,

Please check one of the following options below and sign this form:

\_\_\_\_\_ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

\_\_\_\_\_ I will provide the following meal component to my infant and the center will provide all other meal components:

Formula\*

Meat/Fish/Poultry/Eggs/Beans/Peas

Cereal

Cheese/Cottage Cheese/Yogurt

Fruit

Bread/Crackers/Breakfast Cereal

Vegetable

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

# ANNUAL CHILD HEALTH HISTORY/ASSESSMENT

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_ Date of Enrollment \_\_\_\_\_

Please check all that apply and list any health information needed to care for your child.

Any known allergies/sensitivities to:	No	Yes	If yes, please list
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any chronic illnesses or medical conditions:	No	Yes	Any disabilities:	No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____		

Any additional health information not listed above: \_\_\_\_\_

Medications your child takes: \_\_\_\_\_

Any instructions for your child's daily care: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ Date of last dental examination: \_\_\_\_\_

Name of child's Medical Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of child's Dentist: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Instructions for child's emergency care: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

# Food Allergy Action Plan

Student's

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place  
Child's  
Picture  
Here

ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

### Symptoms:

### Give Checked Medication\*\*:

(To be determined by physician authorizing treatment)

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† \_\_\_\_\_

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

▪ If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change. †Potentially life-threatening.

### DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

### 3. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1.) _____ 2.) _____
b. _____	1.) _____ 2.) _____
c. _____	1.) _____ 2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

(Required)

**Parents or Guardian's  
Notice of No Liability Insurance and Acknowledgement**

I understand that I am being informed in writing by signing this acknowledgement that this facility, \_\_\_\_\_, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

\_\_\_\_\_  
**Parents or Guardian's Signatures**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Guardian (Print Names)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Center Director's Signature**

\_\_\_\_\_  
**Date**

# ACTIVITY AUTHORIZATION FORM

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I hereby grant permission for my child, \_\_\_\_\_

to use all the playground equipment and participate in all of the activities at Creative World Pre-School.

The following restrictions apply:

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I understand that ride on toys, teeter totter, slide, large climber, wading pools, sprinkler, sandboxes and other toys are used on a regular basis.

I will not hold the preschool responsible for injuries incurred while using equipment at the preschool, providing the children are supervised and the equipment is in good repair.

Comments or Concerns noted:

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Parent's Signature: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Photo Release Form for Minors (if under 18)

I \_\_\_\_\_, grant Creative World Pre- School permission to use my child's photograph publicly for promotional use. I understand that the images may be used in print publications, online publications, presentations websites and social media. I also understand no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian's Signature:

\_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Name

\_\_\_\_\_ Date \_\_\_\_\_

Child's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Photo Release Form for Adults

I \_\_\_\_\_, grant Creative World Pre-School permission to use my child's photograph publicly for promotional use. I understand that the images may be used in print publications, online publications, presentations websites and social media. I also

understand no royalty, fee or other compensation shall become payable to me by reason of such use.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_