Children's Enrollment Form

Entrance Date Child's Name Sex Birth Date Age

Social Security Number Parents E-mail Addresses

Home Address Home/Cell Numbers (Provider)

Father's Name/Home Address/Telephone Number, if different from child's

Father's Place of Employment/Address of Employment/ Business Phone Number

Mother's Name/Home Address/Telephone Number, if different from Child's

Mother's Place of Employment/Address of Employment/ Business Phone Number

Child's Living Arrangement: [ ] Both Parents [ ] Mother [ ] Father [ ]Other
Child's Legal Guardian: [ ] Both Parents [ ] Mother [ ] Father [ ] Other
Military Only: FRG Contact _____

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_____Relationship: _____

Name_____Telephone Number_____Relationship: _____

Name_____Telephone Number_____Relationship: _____

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 childcare for _____
(Name of Facility) (Name of Child)

On _____ _____ a.m. to _____ p.m. From _____ to _____.
(Days of Week) (Month) (Month)

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

Breakfast
Morning Snack
Lunch
Afternoon Snack

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

My child will not be allowed to enter or leave facility without being escorted by the parents(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 activates away from the facility, and water-related 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 I 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: _____
(Director)

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*:	☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other†	_____	☐ Epinephrine	☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

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)

The Children's Village

Parent Advisory Facebook Page Photo Release

Dear Parents, The Children's Village Parent Advisory board has a private Facebook page. We update the page with current events that are going on in the classrooms at TCV. This page is only viewed by the parents, and staff of TCV only. Please check below if you would like for your child's picture to be posted on our Facebook page. If you have any questions, please stop by the upstairs office. Thank you.

Child's Name:_____

Child's Classroom:_____

- o Yes I would like for my child to be included in photos posted on the TCV Facebook Page
- o No I would not like for my child to be included in photos posted on the TCV Facebook Page

Parent's Name:_____

Parent's Signature:_____

Date:_____

The Children's Village

Posting Allergies

I give The Children's Village permission to post my child's allergies and medical plan in any or all rooms in the center.

Child's Name:

_____

Parent Signature:

_____

Date: _____

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

ALL ABOUT ME!

WELCOME TO THE CHILDREN'S VILLAGE!

Getting to know your child is the most exciting part of our job. Since there are so many wonderful and unique characteristics to each child, we ask that you fill out the following information to the best of your ability. This will be very helpful to us in the introductory phase of our program.

1. Family members' names:_____
2. Favorite things your child likes to do:_____
3. Food likes & dislikes:_____
4. People & pets your child talks most about:_____
5. Skills your child has recently acquired:_____
6. Skills you would most like your child to learn this year:_____
7. Books your child loves to "read":_____
8. At bedtime, your child likes to:_____
9. Previous group experiences (child care, nursery, church, etc.) your child has had include:

   _____
10. Your child shows an interest in:_____
11. Other languages your child hears at home:_____
12. Your child's bedtime routine:_____
13. Your child finds_____challenging (struggles), and needs to_____
14. Your child is attached to:_____
15. Do you feel your child has any special needs:_____

Please feel free to mention any other qualities your child has or concerns that you may have about their progress. We will gladly meet with you at any time to discuss changes in your child's program or routines.

Thank You! The Staff of The Children's Village

_____

_____

_____ _____

Child's Name D.O.B. Parent's Name