Little Blessings
Christian Childcare Center
503 Old Toll Road, Madison, CT 06443
(203) 421-2878

Enrollment Form

Child's First Name: _____ Child's Last Name: _____
Child's Home Address: _____
Child's Date of Birth: _____ My child's first day will be: _____

Mother's First and Last Name: _____ DOB: _____
Mother's Address: _____
Home Phone: _____ Cell: _____
Mother's Place of Business: _____
Address:_____
Phone:_____ E-mail Address: _____

Father's First and Last Name: _____ DOB: _____
Father's Address: _____
Home Phone: _____Cell: _____
Father's Place of Business_____
Address:_____
Phone:_____ E-mail Address: _____

Parent's marital status (circle one): Single Married Separated Divorced
Custody/Visitation Rights (circle one): not applicable papers attached
Names and ages of siblings': _____
Is your child adopted? Yes No Does he/she know? Yes No
Identify your child's allergies or special needs: _____
Child's physician or health care provider: _____ Phone: _____
Address: _____
Child's Dentist: _____ Phone: _____
Address_____

Designate two responsible persons, other than the child's parents listed on this form, who have permission to remove your child from Little Blessings and who can be used by Little Blessings as Emergency Contacts after presenting proper identification if parents cannot be reached.

First and Last Name _____ Phone/Cell_____
Home Address_____
Relationship to Child_____

First and Last Name:_____ Phone/Cell:_____
Home Address:_____
Relationship to Child:_____

Parent's Signature:_____ Date:_____
Parent's Signature:_____ Date:_____
Director's Signature:_____ Date:_____

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Parent Financial Agreement

To the Parents of _____

1. My registration fee of $100.00 per child is a non-refundable fee paid.

2. A deposit is required of $_____. This amount is equal to one week fee for each child. This amount will be credited to my child's last week with Little Blessings as long as my child attended Little Blessings for four weeks or more.

3. I have selected the following schedule of days and times for my child:

   _____

4. My weekly tuition fee will be: $_____. Payment is due the first scheduled day that my child attends school each week. If payment is not made by Wednesday, I will incur a $25.00 late payment fee each week, until payments are current. I also understand that if my tuition becomes past due for more than 3 weeks, my child may be asked to leave the program until my balance is made current.

5. If I pick up my child past their scheduled departure time, I will incur the following charges:

up to 5 minutes	$25.00
5-10 minutes	$30.00
11-16 minutes	$35.00
17-25 minutes	$40.00
26-30 minutes	$50.00

$50 for each additional half hour or fraction thereof.

** Dropping your child off late at arrival time does not mean you can pick up late at departure time!**

6. Returned check fee is $30.00. If my check is returned for insufficient funds more than two times, I will be asked to pay by money order.

7. If I have past due balance that I am unwilling to pay, I will be responsible for all Collection Agency and/or Court/ Lawyer fees.

8. Discount: A sibling discount of 10% (15% for 3 or more children enrolled) is applied to the fee of the lowest priced child's/children's tuition for a reduction of $_____ per week.

9. I understand that my tuition remains the same regardless of absences due to illness, holidays, vacation or inclement weather.

10. I understand that I am required to give two (2) weeks notice for withdrawal of my child. I am responsible for payment of the two-week period even if my child does not attend.

For Office Use:

Reg Fee Received: _____

Deposit Received: _____

Check #: _____

Date: _____

Parent Signature: _____

Parent Signature: _____

Director's Signature: _____

Date: _____

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* If applicable

Part 1 — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months?	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT**____in/cm_____% ***Weight**____lbs._____oz /_____% **BMI**____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/ ____ (Annually at 3–5 years)

Screenings

***Vision Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
- ❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑Unable to assess

❑Referral made to: _____

***Hearing Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
- ❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑Pass
	❑ Fail	❑Fail

❑Unable to assess

❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑No ❑Yes

***TB:** High-risk group? ❑No ❑Yes

Test done: ❑No ❑Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑No ❑Yes

❑Referral made to: _____

Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑No ❑Yes: ❑Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent ❑Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II

Seizures ❑No ❑Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑No ❑Yes This child may fully participate in the program.

❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 10/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____
Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child Emergency / Medical Permission Card

Attachment 9b, 9c, Rev. 5/03

Little Blessings Christian Childcare Center, 503 Old Toll Road, Madison, CT 06443 (203) 421-2878

Last Name of Child:	First Name of Child:	Child's DOB	Male/Female
Child's Home Address:		Identify Child's Special Needs:	
Name of Mother	Mother's Home Phone	Mother's Cell Phone	Mother's Work/Business Phone
Mother's Home Address		Mother's E-mail address:	
Name of Father	Father's Home Phone	Father's Cell Phone	Father's Work/Business Phone
Father's Home Address		Father's E-mail address:	
Name of child's doctor	Doctor's Phone	Doctor's Address	Insurance Carrier
Name of Child's dentist	Dentist's Phone	Hospital Preference	Insurance Policy #
Designate two responsible persons, other than the parents, who have permission to remove this child from Little Blessings Christian Childcare Center and who can be used by Little Blessings Christian Childcare Center as Emergency Contacts when parents can not be reached.		Name Address Home Phone Cell Phone Relationship to Child	Name Address Home Phone Cell Phone Relationship to Child

I have read and received Little Blessings Christian Childcare Center's Emergency Plans for fire, weather, medical and evacuation procedures. I give Little Blessings Christian Childcare Center my consent to follow each of the procedures for my child _____ while at Little Blessings Christian Childcare Center.
I understand the information on this card will be used in case of fire, weather, medical and evacuation procedure. Therefore I will complete a new card, as necessary, if any information changes.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

Little Blessings
Christian Childcare Center

Emergency Transportation Authorization

Child's Name: _____

I give my consent to Little Blessings Christian Early Learning Center to transport my child, in the event of a school or town emergency to a safe facility by the most expedient means i.e. public or private vehicles.

It is understood that a conscientious effort will be made to notify me before such action is taken if time permits.

I also authorize an acting representative of the school to give consent for any and all necessary emergency medical care for my child(ren) while they are in the center's care.

_____ _____
Signature of Parent or Guardian Date

I am available during an emergency to transport Little Blessings children to a safe destination.
Yes_____ No_____

Little Blessings
Christian Childcare Center

Photo Release

Your children will be doing many fabulous things throughout their day at Little Blessings and we know that you, as parents, treasure a sneak peek into your child's day. We have several ways to give you a peek into your child's day. Our Brightwheel app is a wonderful way to share photos and videos of the children with parents throughout the day, these photos will be only be available to other parents of children in your child's class.

We also have a public Facebook page which is open to the public, and a **private** Facebook group **only for parents and grandparents** we use to share photos.

Please indicate your level of photo participation	**Please Check One** Grant Permission	Decline Permission
Pictures of your child posted in the classroom and in projects your child completes.	☐	☐
Pictures posted on Brightwheel and shared with you and other class parents.	☐	☐
Pictures posted in our **private** Facebook group shared with other parents and grandparents.	☐	☐
Pictures posted on our public Facebook page.	☐	☐
Pictures posted on public pages of the school website and marketing materials.	☐	☐

If you are opposed to photos of your child being taken by the teachers, we do ask that you seriously consider the benefits of your child being included in classroom pictures. Documenting the process of learning by taking pictures of the children and making them available for children in the classroom in the form of projects or storyboards is a powerful learning tool for young children.

Child's Name_____ Parent's Name: _____

Signature: _____ Date_____

Little Blessings
Christian Childcare Center

Child's Name: _____ Date: _____

Class List Permission

I give permission for my child's name, address, and telephone number to be included on the Little Blessings Christian Childcare Center's "Friend's List.". The list of your child's classroom friends will be distributed to student's families, upon request, for the purpose of socializing. If all classmates are invited to your child's birthday, then it is appropriate to distribute them at school. If all children are not invited, please mail the invitations directly to the homes of the children.

- ☐ Yes, I give permission.
- ☐ No, I do not give permission

_____ _____
Parent/Guardian Signature Date

Little Blessings
Christian Childcare Center

October 30, 2023

Digital Camera Policy

To ensure the safety and security of all children, staff and parents, Little Blessings is now equipped with a 24-hour digital camera system. Security cameras have been installed in our classrooms, hallways, outdoor play area, indoor play area and parking lot. We may conduct video surveillance of any portion of our premises at any time, the only exception being private adult restrooms. Our video/security cameras have been positioned in appropriate areas both inside and outside of our facility and are used in order to help promote safety and security.

Because we respect the privacy of all children, parents and staff in our center, our video surveillance/security cameras are for internal purposes only. Only the Director and a designated Board Member will have access to recorded or live video footage.

Video surveillance/recording acknowledgement forms are signed prior to your child(ren) enrolling at Little Blessings and are a condition of enrollment.

Child's Name: _____

Parent Signature: _____

Date: _____