Little Blessings
Christian Childcare Center

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_____

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 I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). 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/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

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

* If applicable

Part I — 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 II — 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. 3/2015

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	
Influenza						
Tdap/Td						

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 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	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]	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 on or 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

Little Blessings
Christian Childcare Center

503 Old Toll Road, Madison, CT 06443
(203) 421-2878

Parent Financial Agreement

To the Parents of _____

1. My registration fee of $80.00 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 5 minutes of their scheduled departure time, I will incur the following charges:

6 – 15 minutes	$20.00
16-30 minutes	$25.00
31-45 minutes	$35.00
46-60 minutes	$40.00

***** 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% 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: _____

Revised 8/2020

Child Emergency / Medical Permisson 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 Learn & Play Christian Early Learning 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

COVID-19 Parent Agreement

Before your child(ren) may attend class at Little Blessings Christian Childcare Center, please read, initial next to each statement and return the following agreement. These policies are put in place to keep your child, yourself, and our staff safe, and are subject to change.

_____ _____

Child's name Parent's name

I understand that…….

_____ My child cannot attend Little Blessings Christian Childcare Center if my child **OR** anyone in my house has been exposed to someone who has tested positive to COVID-19 **OR** if we have any COVID-19 symptoms **OR** if my child or anyone in my house has or has had a temperature of 100 degrees F or higher in the past 3 days.

_____ My child cannot attend Little Blessings if they have been given fever reducing medication for any reason, as this can mask the signs of sickness.

_____ The person dropping off and picking up my child will need to wear a mask while at Little Blessings, as will any siblings that do not attend Little Blessings.

_____ When picking up or dropping off my child, I will adhere to the 1 adult per family.

_____ I will adhere to social distancing while at Little Blessings and I will keep my child with me at all times.

_____ When dropping off my child I will wait outside of the assigned doorway until greeted by the designated person to complete the health assessment check in. If waiting outside, I will keep to the 6 foot social distancing requirement.

_____ I will have my temperature and my child's temperature taken daily by the director or designated person, as well as fill out a health assessment before my child is cleared to attend each day.

_____ I understand that I need to be **honest** when I fill out the health assessment in order to not spread germs.

_____ I understand I will **not** be allowed inside my child's classroom for drop off or pick up.

_____ I understand that door codes will not be distributed at this time.

_____ I will supply my child with their own utensils and water bottle to be taken home daily to be washed.

_____ I will pack my child's snack(s) and lunch in a hard lunchbox with an ice pack. No refrigeration will be provided except for milk bottles in the infant room..

Infants' refrigerator is for milk bottles only

_____ I will supply my child with two shoebox sized plastic containers, one for classroom supplies (e.g crayons, markers, scissors, playdough etc.) and one for sensory play, labeled with their name.

Please see your classroom teacher for what is needed, as each classroom has different needs

_____ I understand that if my child attends the Preschool/Pre-K class, as per The Office of Early Childhood, they are required to wear a mask. Mask breaks will be during snack, lunch, rest and outside time.

_____ If at any time the Director feels my child is sick and should not be at the Little Blessings Christian Childcare Center, I will adhere to the COVID-19 sick policy and pick them up within a thirty minute window.

_____ I understand by not following these policies I am jeopardizing my child's enrollment at Little Blessings Christian Childcare Center.

_____ I understand that having my child attend Little Blessings Christian Childcare Center is my choice and that I cannot and will not hold Little Blessings Christian Childcare Center liable for any sickness incurred.

_____ I understand that these polices may change without notice in accordance with guidelines from the Office of Early Childhood, local and State Health Departments and the CDC.

Parent 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 each student's family 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

Photograph Permission

I give permission for pictures of my child to be taken by the Little Blessings Christian Childcare Center staff for use in our programs. These pictures might include children participating in daily activities or special programs and may be posted on bulletin boards in the classroom or elsewhere in the school building, used in school event slideshow (i.e. end of year). Pictures may also be placed on the Little Blessings Christian Childcare Center's Facebook page (open to parents, grandparents and current staff only, director approves all people allowed on our Closed Facebook page). I understand I will be notified if my child's picture will be used by the local newspaper or in center advertising outside of the building and will have the ability to give or deny permission at that time. Little Blessings intends to give printed pictures to families when no longer needed.

- ☐ Yes, I give permission for pictures of my child to be used in the classroom and school building.
- ☐ Yes, I give permission for pictures of my child to be posted on the Little Blessings **Private** Facebook Group.
- ☐ Yes, I give permission for pictures of my child to be used in Little Blessings public advertising

_____ _____
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_____