Enrollment Application

GiggleBugs Early Learning Center

In order to be fully enrolled at GiggleBugs, this ENTIRE packet must be complete. Please respond to EVERY question. If a section does not apply, please write N/A. Your completed packet, registration fee, security deposit, and first week's payment must be received BEFORE your child is officially enrolled at GiggleBugs. Thank you.

Child's Name: ______________________________ **Date of Birth:** __________

Enrollment Date: ______

Discharge Date: ______

Reason for Discharge: ____

Child Information:

Child Name ____________________
Child Address ____________________
Home Phone ____________________
Date of Birth ____________________
Sex _____Male _____Female
Email Address ____________________ (Required for Information & Updates)

Mother Information: Circle One: Mother Stepmother Grandmother Guardian

Mother's Name ____________________
Address ____________________
Home Phone ____________________ Cell Phone ____________________
Employer ____________________
Employment Hours ____________________
Work Phone ____________________

Father Information: Circle One: Father Stepfather Grandfather Guardian

Father's Name ____________________
Address ____________________
Home Phone ____________________ Cell Phone____________________
Employer ____________________
Employment Hours ____________________
Work Phone ____________________

Payment Type: (Circle One) Self Pay POC Plus

Check Any That Apply: (If checked, provide an explanation beside each item)

_____ Medical Condition Alert ____________________

_____ Allergy Alert ____________________

_____Custody Alert ____________________

Preferred Medical Facility: ____________________

Doctor:

Name____________________
Phone____________________

Emergency Contact Information: (Note: At least 2 individuals MUST be listed)

Persons authorized to act in an emergency if parents cannot be contacted.

Name ______________________________ Relation to Child: ______________
Phone ____

Name ______________________________ Relation to Child: ______________
Phone ____

Name ______________________________ Relation to Child: ______________
Phone ____

Persons Authorized to Pick Up Child: (Note: At least 2 individuals MUST be listed)

***Persons must present a photo ID that matches information placed below.

Name ____
Phone ____

Name ____
Phone ____

Name ____
Phone ____

I authorize this early learning center to release my child to the above named persons and give my consent for GiggleBugs staff to discuss matters pertaining to my child with these persons.

____ ______________

Signature of Parent or Guardian Date

Persons who may NOT pick up child:

Name ____
Name ____

Is there a COURT ORDER granting custody, visitation, or otherwise restricting or allowing access to the child? ______YES ______NO

***If YES, a copy of the court order must be provided along with this application.

Health Information:

***A written health assessment and copy of your child's immunization records signed by a licensed health care provider must be submitted to this center **within 30 days of admission**.
Health assessment must have been conducted within the last 12 months prior to admission.
***The health assessment must be updated **YEARLY**.

Does your child have any ALLERGIES or MEDICAL PROBLEMS of which we should be aware?

____

____

Does your child take any prescribed or OTC medications? (On a regular basis? or an emergency only basis?)

____

Is there a special DIETARY need because of a medical condition or any other reason?
(Please request a special dietary form to be signed by a physician so we can make substitutions to the menu for your child. Required by CACFP.)

____

____

Has your child experienced a past/previous significant illness or injury? If so, explain.

____

Has your child experienced any recent changes? (divorce, death in family, new sibling, a move to a new location, etc)

____

Does your child have any of the following: (Circle any that apply & provide a copy)
IEP IFSP 504 Plan Other special need to be considered: ________________

Child's Health Insurance Company: ______________________________
Health Insurance Policy Number: ______________________________

Authorization For Staff To Act In Emergency:

In the event of a medical emergency, the center staff will immediately attempt to contact one or both parents. If the parents cannot be reached, staff will attempt to contact the persons listed on the emergency contact list. IF NEITHER THE PARENTS NOR THE PERSONS ON THE EMERGENCY CONTACT LIST CAN BE CONTACTED, CENTER STAFF IS AUTHORIZED TO OBTAIN EMERGENCY MEDICAL EVALUATION AND/OR TREATMENT FOR THE CHILD.

***PLEASE NOTE: IF A STAFF PERSON BELIEVES YOUR CHILD'S CONDITION IS **LIFE ALTERING OR LIFE THREATENING**, THE STAFF MEMBER WILL IMMEDIATELY CALL 911 AND REQUEST AN AMBULANCE WHILE ANOTHER STAFF MEMBER ATTEMPTS TO CALL THE PARENT TO MEET AT THE PREFERRED MEDICAL FACILITY.

______________________________ ________________
Signature of Parent/Guardian Date

Photograph, Audio, & Video Tape Permission:

I give GiggleBugs ELC permission to photograph, audio, or video tape my child during special activities. These may be used in the center, in the newspaper, in our newsletters, or on our website and/or Facebook page. I also authorize the video taping of my child as a part of routine security procedures.

______________________________ ____________
Signature of Parent/Guardian Date

If Child Is **School Age**:

Name of School: ______________________ Phone # of School: ____________

Release for the Indian River School District &/or Telamon to Pick Up & Drop Off:

My child, ________________________, has permission to be picked up and/or dropped off at GiggleBugs ELC by Indian River School District's and/or Telamon's transportation. A designated staff member will walk your child to the end of the walkway to be picked up and/or dropped off and will sign in/out your child.

______________________________ ____________
Signature of Parent/Guardian Date

Date of Enrollment: ____________ Start Date: ____________

Circle One: Full Time Part Time

Circle Days Child will Attend Center:

Monday Tuesday Wednesday Thursday Friday

Hours Child Will Attend Center: (approximates)

From: ________________________ a.m. p.m.
To: ________________________ a.m. p.m.

WRITE TIME- If Different Hours on Different Days

____
____

I have met with the center Administrator and discussed the center's statement of purpose including center's policies on behavior management, reporting of abuse & neglect, health & medication, confidentiality & information disclosure, discharge policies, and grievance procedure. I have received a copy of the Parent Handbook, and I understand my right to grieve without retaliation against my child or myself. I have been informed of my right to make a complaint to the state related to the center's compliance with DELACARE regulations.

______________________________ ____________
Signature of Parent/Guardian Date

Child Information Card:

Admission Date __________ Date of Discharge ____________

Name of Child: ____ ___Male ___Female

Last Name First Name Middle Initial

Date of Birth: ___________________ Days/Hours Child Scheduled to Attend (circle): M T W TH F

___________am-__________pm

Child's Address: ____ Home Phone: ________________

____

Physician Name/City,State: ______________________________________ Physician Phone: ______________

Dentist Name/City, State: ______________________________________ Dentist Phone: ________________

Preferred Hospital/City, State: _____________________________________ Hospital Phone: ______________

MOTHER/GUARDIAN #1 NAME/ADDRESS: ____

____

Home Phone: __________________________________ Cell Phone: __________________________________

Employer/School Name: ____

Employer/School Phone: __________________________ Employer/School Hours:________________________

FATHER/GUARDIAN #2 NAME/ADDRESS: ____

____

Home Phone: __________________________________ Cell Phone: __________________________________

Employer/School Name: ____

Employer/School Phone: __________________________ Employer/School Hours:________________________

Name of Primary Health Insurance Carrier: ____

Health Insurance ID Number/Group Number:____

Child's medical conditions, allergies, illnesses, regular medications, special needs, concerns:________________

____

____

____

EMERGENCY CONTACTS: Names of individuals to contact when parents/guardians cannot be reached. Note: You are authorizing GiggleBugs staff to discuss matters pertaining to your child with these individuals. *Must list at least **TWO**.

1.____ ____________________

Name Home/Cell #

2.____ ____________________

Name Home/Cell #

3.____ ____________________

Name Home/Cell #

EMERGENCY PICK-UP: Name of individuals with permission to pick-up child from GiggleBugs ELS. NOTE: You are giving consent for GiggleBugs staff to discuss matters pertaining to your child with these individuals. *Must list at least TWO.

1.______________________________ ______________
Name Home/Cell #

2.______________________________ ______________
Name Home/Cell #

3.______________________________ ______________
Name Home/Cell #

SPECIAL INSTRUCTIONS: Biological/Custodial parents must be given access to their child(ren) unless there is a court order preventing contact. Individuals with court orders against them preventing child pick up:

______________________________ ______________
Name Relationship to Child

______________________________ ______________
Name Relationship to Child

EMERGENCY MEDICAL CARE AUTHORIZATION

I, ______________________,(parent/legal guardian) give permission for GiggleBugs ELC staff to consent for ______________________, to receive emergency medical, dental, or surgical treatment if I cannot be reached. I understand I will be financially responsible for the cost of such treatment.

TRANSPORTATION AUTHORIZATION

I, ______________________, (parent/legal guardian) give permission for GiggleBugs ELC staff to transport my child,______________________, in the following situations:

(INITIAL ON APPLICABLE LINES)

_______ for non-emergency reasons such as to/from the center, field trips, etc

_______ in the event of an emergency

_______ in the event of an emergency, I PREFER that an ambulance transport my child

*****NOTE: IF YOUR CHILD IS DEEMED BY GIGGLEBUGS ELC STAFF TO BE EXPERIENCING A LIFE ALTERING OR LIFE THREATENING EMERGENCY, 911 WILL BE CALLED AND YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO RECEIVE EMERGENCY MEDICAL CARE. I UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE FOR THIS COST.**

By signing below, I certify that the information I have provided is accurate and that I am the legal guardian of the above named child. I understand that it is my responsibility to notify GiggleBugs ELC in writing of any changes to my child's emergency contact information, medical conditions, or authorizations I have listed or acknowledged on this form. I further certify that I have read and understand this form and that my consent is freely and voluntarily given.

______________________________ ______________
Parent/Guardian Signature Date

Child's Name ______________________ **CENTER REQUIRED SIGNATURES**

PARENTS RIGHT TO KNOW NOTICE

UNDER THE DELAWARE CODE YOU ARE ENTITLED TO INSPECT THE ACTIVE RECORD AND COMPLAINT FILES OF ANY LICENSED CHILD CARE FACILITY. TO REVIEW A CHILD CARE FACILITY RECORD CONTACT: Naomi Gosch, 821 Silver Lake Boulevard, Suite 103, Dover, Delaware 19904, phone (302)739-5487.

You may also view substantiated complaints and compliance review histories for the past three years by visiting http://www.apex01.kids.delaware.gov:7777/occl/

I acknowledge I received this notice as part of the application packet. ______________________ **Parent/Guardian Signature** __________ **Date**

PARENT PERMISSION FOR DVD/TV VIEWING

Children, over the age of 2 years old, may have an educational movie or program incorporated into their curriculum. Movies shown will be age appropriate and not exceed one hour in length.

I hereby authorize my child to watch educational movies. ______________________ **Parent/Guardian Signature** __________ **Date**

PARENT PERMISSION FOR COMPUTER USAGE

Children, over the age of 2 years old, will have the opportunity to occasionally play educational games on the computer. Children will be closely supervised to ensure that age-appropriate and educational websites are being viewed while using the internet. Computer time will not exceed one hour in length.

I hereby authorize my child to use the computer. ______________________ **Parent/Guardian Signature** __________ **Date**

RECEIPT OF PARENT HANDBOOK

I certify that I have received information regarding the Center's policies on following topics: a typical daily schedule, positive behavior management techniques, routine and emergency health care, health exclusions, and prevention of communicable diseases, food and nutrition, procedures for releasing children, reporting of accidents, injuries or critical incidents, mandatory reporting of child abuse and neglect, administration of medication procedures, non-discrimination, developmental and educational goals, complaints, and transportation, if provided.

______________________ **Parent/Guardian Signature** __________ **Date**

TRANSPORTATION PERMISSION I hereby give permission for my child to be transported by ______________________________________.

Please list any special needs or problems which might require special attention during transportation and directions on how to handle the special need or problem. This information will be carried with the operator of the vehicle named above. **Each field trip requires separate written parent permission for transportation and attendance.**

____

____

____

______________________ **Parent/Guardian Signature** __________ **Date**

NAME____________________

BIRTHDATE__________

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

- ☐ Allergies (food, medicine, bee sting etc.)
- ☐ Constipation/Diarrhea
- ☐ Frequent Colds
- ☐ Hearing Difficulty
- ☐ Seizures
- ☐ Fainting
- ☐ Speech Difficulty
- ☐ Vision Difficulty
- ☐ Physical Handicap
- ☐ Behavior Problem
- ☐ Asthma

Other____

Comments:____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

____

____

Parent/Guardian's Signature______________________________ Date______________

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin _____ Heart _____ Vision _____ Ear, Nose _____ Lungs

_____ Hearing _____ Throat _____ Abdomen _____ Blood Pressure _____ Eyes

_____ Genitalia _____ Teeth _____ Extremities _____ Neck, Glands _____ Nervous System

_____ Height _____ Weight

REMARKS AND RECOMMENDATIONS: ______________________________

____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? ______________________________

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's Signature______________________ ☐ M.D. ☐ P.N.P. Date:______________

Printed Name:______________________ Telephone:______________

DOC.NO. 37-08-10-01-01-01

GIGGLEBUGS POC CONTRACT FOR CHILD CARE SERVICES
FEE AGREEMENT:

Child's Name: ______________________________ Date of Birth: ____________
Address: ______________________________ Phone: ______________
City: ____________________ State __________ Zip Code: ____________

This **"Contract for Child Care Services Fee Agreement"** is made on this ________ day of ____________________, 20____, by and between GiggleBugs Early Learning Center and ________________________, the parents/guardians of the above listed child.

GiggleBugs Early Learning Center agrees to provide child care services for the above named child. The child is enrolled on the following days of the week for the time indicated each day:

FULL TIME Monday-Friday _____am-_____pm $15/15 min increment past authorization

Classroom assignments are made based upon the age of the child in accordance with child care licensing regulations. GiggleBugs Early Learning Center may change the child's classroom assignment based upon center enrollment and ratio requirements.

A late pick up fee of $15 per each 15 minute increment will be billed to the parent/guardian's account if time beyond approved POC hours are utilized. Late fees are due by the next billing week.

Any requests for changes to the enrollment schedule listed herein must be made in writing and submitted to the Administrator and will require the execution of a new Contract for Child Care Services Fee Agreement and payment of any additional security deposit and/or tuition increase. GiggleBugs reserves the right to deny any request for schedule change for any reason within its sole discretion.

________________________, the parents/guardians of the above listed child agree to compensate GiggleBugs Early Learning Center the above listed services in the amount of ________________ which is to be paid every Friday for services the following week.

Tuition is paid *prior* to services rendered. Tuition is due every Friday by 5:30pm. Tuition is due whether or not the child attends the program (up to 5 absent days per month). The tuition represents the child's place in the program. Credit for closure days will only be given if it is not one of POC's 7 approved holidays or if it's a weather closing that was **not** a Level 2 state of emergency. If tuition is not paid by Monday, your child will not be able to return to GiggleBugs until tuitions are paid up to date. If tuitions are not paid by Friday of the week already served, your child will lose his/her slot.

__________ Please Initial
A security deposit in the amount of one week's tuition must be paid and will be held by GiggleBugs. The security deposit may be used as the last week's tuition payment.

This Contract for Child Care Services Fee Agreement may be cancelled by GiggleBugs at any time with or without notice, in its sole discretion.

__________ Please Initial
This contract for Child Care Services Fee Agreement may be cancelled by the PARENTS/GUARDIANS with a ***one*** week **written** notice. Written notice of cancellation must be submitted to Jennifer Spinks by Parent/Guardian. The security deposit will first be applied to any unpaid account balance. The security deposit may also be used to pay for what should be the last week of care if a parent fails to provide a 1 week notice as per POC policy. Any unused tuition paid by the parents/guardian will be refunded within 30 days of cancellation.

GiggleBugs may implement a rate increase with a 30 day written notice. Upon receiving written notice of a rate increase, you may choose to withdraw your child from GiggleBugs with a *one* week notice, or you may keep your child enrolled and pay the new weekly rate.

Failure to comply with our tuition policy will be cause for immediate dismissal from our program and the possibility of legal action which could have an adverse effect on your credit.

By signing below, I/we the parents/guardians of the above listed child hereby acknowledge that I/we have read this Contract for Child Care Services Fee Agreement completely, that I/we have had the opportunity to discuss the information contained herein with a representative of GiggleBugs, that our questions have been answered fully and to our satisfaction and that we agree to abide by the conditions set forth herein.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

POC PLUS CLIENTS ONLY-
I agree to pay GiggleBugs Early Learning Center the POC PLUS fee in addition to my DSS Parent Fee. GiggleBugs will provide a POC Plus worksheet with a breakdown of DSS payment, parent fee, and the plus rate. I understand that my child may not exceed 5 absent days per month in order to keep my child's POC Plus slot at GiggleBugs.
***If your Parent Fee or our Plus fee changes, you will be provided with a new POC Plus worksheet to sign.**

Parent/Guardian Printed Name	Parent/Guardian Signature	Date