Child Care Registration Form			Date child entered care	Date child left care
Child's name Last	First	Middle	Name (Nickname) used	Birthdate
Street address			City	Zip code
Child's parent/guardian name	home phone # ( ) -		cell phone# ( ) -	alternative phone # ( ) -
Street address			City	Zip code
Address where you can be reached while child is in care			City	Zip code
Child's parent/guardian name	home phone # ( ) -		cell phone# ( ) -	alternative phone # ( ) -
Street address			City	Zip code
Address where you can be reached while child is in care			City	Zip code

Other than you, who else has permission to pick up your child?

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code
Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.	
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.	
Child's dentist's name		Telephone number ( ) -
Street address	City	Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee Little Scholars Development Center,

Address of Licensee 2016 N Monroe.

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

Child Care Agreement

	First	Middle	Last
Child's name:			
Parent or guardian name:	First	Middle	Last
Parent or guardian name:	First	Middle	Last

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

Fee: $ per: Month

☐ Hour ☐ Day ☐ Week ☐ Month

Date payment due: 1st of every month

Source of payment: ☐ Parent ☐ Other (specify):

Overtime rate: $2.50 per minute

Late fee: $15 per month (if payment later than the 1st)

Other Fees: $ Resource fee Description: Reference pg. 3 of parent hand book.

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by

Little Scholars

Name of licensee

Parent or guardian signature	Date	Parent or guardian signature	Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Management — Licensee signature

7/3/19 — Date

2015 N Monroe — Street address

Spokane — City

WA — State

99205 — Zip code

Comments

Little Scholars Development Center

General Permission Authorization

Child's Name: First Middle Last	License's Name
	Little Scholars, ELC

The licensee has permission to transport my child in a motor vehicle to go:

	Yes	No
1. To obtain medical care	☐	☐
2. To and from school	☐	☐
3. On field trips	☐	☐
4. Other (specify below)	☐	☐

The license has permission to:

	Yes	No
1. Take my child on walks	☐	☐
2. Take my child on public transportation (preschool fieldtrip only)	☐	☐
3. Take my child swimming (preschool fieldtrip only)	☐	☐
4. Take photographs of my child (medical, center and marketing use)	☐	☐
5. Give my telephone number and address to other parents	☐	☐
6. Allow my child to eat foods brought by other parents (store bought)	☐	☐
7. Other (specify below)	☐	☐

Parent or guardian signature Date	Parent or guardian signature Date

Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ☐ Yes ☐ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:

Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required Date

Vaccine	Dose	Date Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● *Haemophilus influenzae* type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name	Date	Printed Staff Name	Date
Printed Staff Name	Date	Printed Staff Name	Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) ☐ **Chickenpox disease verified by printout from CHILD Profile Immunization Registry**
Must be marked by printout (not by hand) to be valid.

2) ☐ **Chickenpox disease verified by Health Care Provider (HCP)**
If you choose this box, mark 2A OR 2B below.
2A) ☐ Signed note from HCP attached OR
2B) ☐ HCP signed here and print name below:

Licensed health care provider (HCP) Signature Date
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

3) ☐ **Chickenpox disease verified by school staff from CHILD Profile Immunization Registry**
If you choose this box, staff must initial that parent or guardian approves: _____(initial) _____(date)

4) ☐ **Chickenpox disease verified by parent***
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease: _____
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

☐ Diphtheria	☐ Mumps	☐ Other: _____
☐ Hepatitis A	☐ Polio	
☐ Hepatitis B	☐ Rubella	
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

Licensed health care provider (HCP) Signature Date
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

Washington State Department of Health

DOH 348-106 June 2011

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements[1]

DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').[2] Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):	Sex:	Parent/Guardian Name (please print):

Parent/Guardian, please choose the exemption(s) that apply to your child below.

☐ **Temporary Medical Exemption**
☐ **Permanent Medical Exemption**

_____ Until _____
Vaccine(s) Date (or Permanent)

Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X _____ X _____
Signature of Licensed Health Care Provider Date

☐ **Personal/Philosophical Exemption (see Box 1)**
☐ **Religious Exemption (see Box 1)**
☐ **Religious Membership Exemption (see Box 2)**

I do not want my child to get the following vaccine(s):

☐ Diphtheria ☐ Hepatitis B ☐ Hib
☐ Measles ☐ Mumps ☐ Pertussis (whooping cough)
☐ Pneumococcal ☐ Polio ☐ Rubella
☐ Tetanus ☐ Varicella (chickenpox)

☐ Other (indicate):

Box 1

Provider Statement[2]: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons."

X _____
Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X _____
Date

Box 2

Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption."

X _____
Name of Church or Religious Body

X _____ X _____
Signature of Parent or Guardian Date

Box 3

Parent/Guardian Statement: "I certify that all the information provided on this certificate is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care, or preschool until the outbreak is over."

X _____ X _____
Signature of Parent or Guardian Date

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

[1] RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

[2] A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ☐ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
2) ☐ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
3) ☐ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
4) ☐ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports.**

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference Guide

Vaccine Trade Names in alphabetical order

(For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (ProQ)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order

(For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

DOH 348-013 January 2010

Request for Fluid Milk Substitution – Child Care

Child's Name: _____

Milk substitution request:

If your child cannot drink fluid cow's milk due to medical or other special dietary needs but **does not** have a diagnosed medical disability, you or the child care center may choose to provide one of the approved non-dairy milk substitutes or creditable milk substitutes below, based on your request.

Identify why your child needs a milk substitute: _____

_____

At this time, only five brands of non-dairy milk substitutes available in Washington are nutritionally equivalent to and may be served in place of cow's milk:

- 8th Continent Soymilk (Original and Vanilla*)
- Great Value Original Soymilk
- Kirkland Organic Soymilk (Plain)
- Pacific Ultra Soy (Plain and Vanilla*)
- Silk Original Soymilk

***Effective October 1, 2017, flavored non-dairy beverages cannot be served to children 1 through 5 years of age. If serving flavored milk to children 6 years of age and older, it must be nonfat milk.**

Other milks that are creditable and may be served in place of fluid cow's milk are acidified milk, acidophilus milk, buttermilk (commercially prepared), goats milk, Kefir milk, lactose-free or reduced milk (such as Lactaid), and organic milk. **Note: Whole milk must be served to children 12 to 24 months and nonfat or 1% milk must be served to children 2 years of age or older.**

By completing the information below, your child can be served one of the approved non-dairy milk substitutes or other creditable milks noted above provided by the center (if the center chooses), or provided by you.

_____ I request my child be served the child care center provided approved non-dairy or creditable milk substitute as described above for meals that require milk.

_____ I will provide an approved non-dairy or creditable milk substitute to be served to my child as described above for meals that require milk:

_____
(Name of approved non-dairy or creditable milk substitute)

Signature of Parent/Guardian: _____ Date: _____

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month – Tell us how much and how often (or net income if self-employed) (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	*$200 / weekly*	*$150 / 2x/month*	*$100 / monthly*	
1.	$ /	$ /	$ /	
2.	$ /	$ /	$ /	
3.	$ /	$ /	$ /	
4.	$ /	$ /	$ /	
5.	$ /	$ /	$ /	
6.	$ /	$ /	$ /	

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing Social Security Number (last four digits) XXX-XX-	☐ I do not have a Social Security Number
Address	City/State/Zip Code	Daytime Phone	

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

CENTER USE ONLY

☐ Child(ren) are categorically ☐ free based on ☐ Basic Food ☐ TANF ☐ FDPIR

☐ Foster child(ren) have been identified on this form and qualify for the ☐ free category.

Annual Income Comparison: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

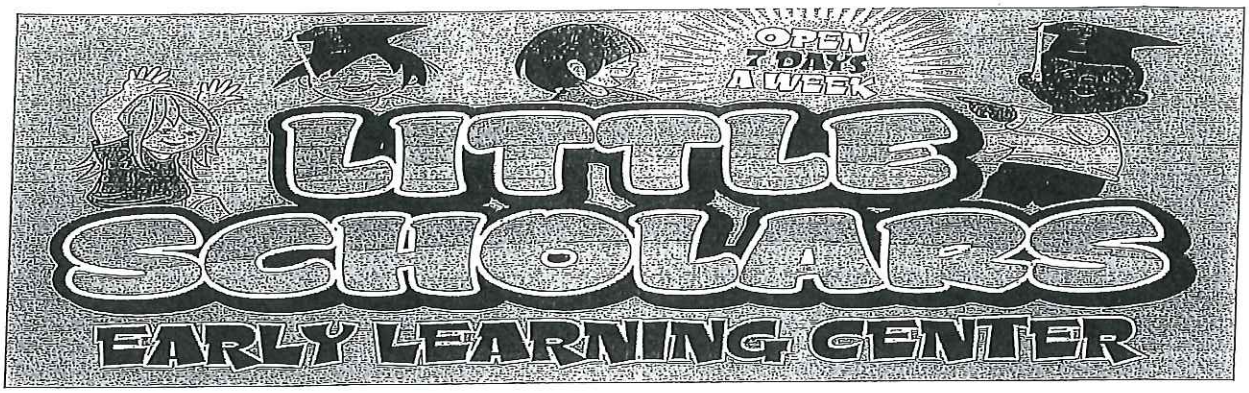
☐ Child(ren) on this form who are not categorically eligible qualify as follows:

Check one:
- ☐ Free
- ☐ Reduced-Price
- ☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

_____ _____
Signature of Institution's Representative Date

Valid for one year from the date of the institution representative's signature. **Invalid without signature and date.**



Hello Parents,

Little Scholars ELC is going to become more present on social media! We will be posting pictures of daily activities, play time activities and many more! You will be able to see your children and others interacting threw Facebook page and will be notified on any changes in the center!

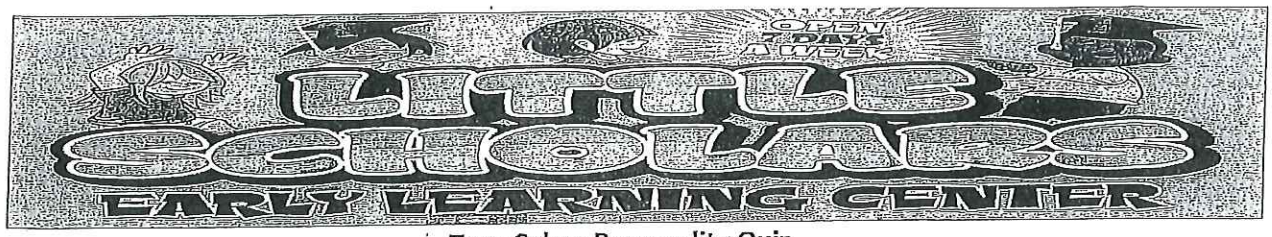
If you don't mind your child's pictures being posted on our social media please check the yes box and sign, if not then check no and sign. Please turn these papers in to Management!

YES

NO

Signature:

Child's Name:



True Colors Personality Quiz

Name: _____

Describe Yourself/Your child: In the boxes below are groups of word clusters printed **horizontally** in rows. Look at all of the choices in the first box (A, B, C, D). Read the words and **decide which of the four letters is the most like you.** Place a 4 next to the letter that is the most like you, the rank the next three letters from 3-1 in descending preference. You will end up with a box of four letter choices, ranked from "4" (most like you) to "1" (Least like you). Continue this process with the remaining four boxes until you have a 4, 3, 2, and a 1.

Box one:			
A_____	B_____	C_____	D_____
Active	Parental	Authentic	Versatile
Opportunistic	Traditional	Harmonious	Inventive
Spontaneous	Responsible	Compassionate	Competent

Box Two:			
E_____	F_____	G_____	H_____
Curious	Unique	Practical	Competitive
Conceptual	Empathetic	Sensible	Impetuous
Knowledgeable	Communicative	Dependable	Impactful

Box Three:			
I_____	J_____	K_____	L_____
Loyal	Devoted	Realistic	Theoretical
Conservative	Warm	Open-Minded	Seeking
Organized	Fun	Dramatic	Composed

Box Four:			
M_____	N_____	O_____	P_____
Concerned	Daring	Tender	Determined
Procedural	Impulsive	Inspirational	Complex
Cooperative	Fun	Sympathetic	Composed

Box Five:			
Q_____	R_____	S_____	T_____
Philosophical	Vivacious	Exciting	Orderly
Principled	Affectionate	Courageous	Conventional
Rational	Sympathetic	Skillful	Caring

A,H,K,N,S- Orange:_____

B,G,I,M,T- Gold: _____

C,F,J,O,R- Blue:_____

D,E,L,P,Q- Green:_____

Little Scholars Early Learning Center
Individual Plan for Specialized Care

Childs Name	Date of Birth	Classroom

Area of Concern:

Adaptive Equipment and supplies Needed at the childcare center:

Medication/ Treatment Child is to receive at Facility during childcare hours:

Symptoms/indicators/possible relating to child condition/ treatment

Center Supervisor Signature and date

Physician/Specialist signature and date

Parent/guardian Signature and date

Office Usage Only:

Medication Storage: _____

Training on medication: _____

Staff trained: _____

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

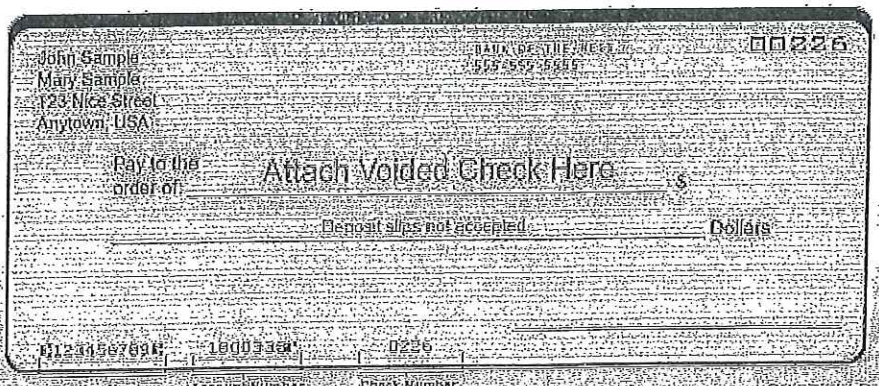
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

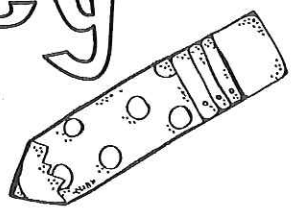
For Official Use Only

Date Received
Employee Signature



A service of procare SOFTWARE

Parent Survey



This information sheet is to help me better understand your child. Please be honest and provide details where necessary.

1. Student Name: _____ Date of Birth: _____
2. Name of Parent (s)/Guardian?

   _____
3. Home Address: _____
4. Please ***star*** the best way for you to be contacted if needed

   Home phone: _____

   Mom's work: _____ Mom's Cell: _____

   Dad's work: _____ Dad's Cell: _____

6. Emergency Contact Person (This information must be on file with the front office). Contact person/relationship to student: _____

   Phone number: _____

7. Are any languages other than English spoken at home? _____
8. What is the primary way your child will go home each day? _____

*Please send a note if there are going to be any changes in dismissal.

9. Do you have any special concerns about your child? (academically, socially, medically, etc.)?

   _____

10. Please list any foods, stings, etc. that may cause allergic reactions with your child

    _____

11. Please list two goals you would like to set for your child this year:

    _____

    _____

12. Please tell me, in one million words or less, if there is anything else I should know about your child. Feel free to brag! Use the back if you need to.

    _____

    _____

    _____

    _____

    _____

Parent Handbook - Acknowledgement

I have read and understand the attendance reminders and updates. My initials below are a written representation of my acknowledgment and assumed responsibility for any fees that may occur:

_____Our Mission
_____Our Philosophy
_____Our Cultural Awareness Philosophy
_____Our Curriculum Philosophy
_____Enrollment and Disenrollment Requirements
_____Fee and Payment Plan
_____Scheduling
_____Directors Absence
_____Payment in Lieu of Absence
_____Typical Daily Schedule and Activities
_____Typical Meals and Snacks
_____Permission for Free Access
_____Child Abuse, Neglect and Exploitation Reporting Requirements
_____Child Guidance and Discipline
_____Nondiscrimination Statement
_____Religious Activities
_____Transportation and Offsite Activity Policy
_____Offsite Activities
_____Sign-in and Out Procedures
_____Practices Concerning Ill Child or Staff
_____Medication Management
_____First Aid Including Medical Emergencies
_____Supplies and Clothing to Be Provided
_____Potty Training
_____Emergency Procedures
_____Behavior Policy
_____ Developmental Screener Resources
_____Biting Policy
_____Diaper Policy
_____Center Closure Dates

_____ _____

Parents Printed Name Date

_____

Parents Signature