

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(9)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(8)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)

Birthdate (mm/dd/yyyy)

First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child

Home / Call Phone No.

Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)

Does child reside at this location?
 Yes No

Place of Employment and Work Phone No.

b. Name and Relationship to Child

Home / Call Phone No.

Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)

Does child reside at this location?
 Yes No

Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child

Home / Call Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

b. Name and Relationship to Child

Home / Call Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

Yes No This person is authorized to pick up the child.

Name and Relationship to Child

Home / Cell Phone No.

Email Address Where Reachable While Child is in Care

Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name

Address (Street, City, State, Zip Code)

Telephone Number

AUTHORIZATIONS

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in Transported Walking field trips and other activities during operating hours.
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian

Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(K)5. and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.			
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2. a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

- Check any special medical condition that your child may have.
 - No specific medical condition
 - Asthma
 - Cerebral palsy / motor disorder
 - Other condition(s) requiring special care – Specify.
 - Diabetes
 - Gastrointestinal or feeding concerns including special diet and supplements
 - Epilepsy / seizure disorder
 - Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies – Specify food(s).
- Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under age 2 in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: This form is to be completed by a parent and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI) Nickname (If any) Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI) Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH Note: Health conditions that may affect the care of the child must be recorded on the department's form, Health History and Emergency Care Plan. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule Length of time on current schedule

Food type
 Formula Strained Junior Table Milk type – Specify:

New food timetable

When eating, child is –
 Held in lap In highchair Other – Specify:

Feeds self
 Yes No If "Yes", uses: Spoon Fork Hands

Special feeding problems
 Yes No If "Yes" – Specify:

Food allergies
 Yes No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule	Length of time on current schedule
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Falls asleep easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Mood upon awakening – Describe.
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Takes favorite toy(s) to bed – **child over age 1 year**
 Yes No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**
Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.
 Back for children under age 1 year Side or stomach (physician statement attached)

Sleep position – **child over age 1 year**
 Back Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type <input type="checkbox"/> Cloth <input type="checkbox"/> Disposable	Diapers provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No
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Plastic pants used
 Always Never Sometimes If "Sometimes" – Specify:

Highly sensitive skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diaper rash <input type="checkbox"/> Yes <input type="checkbox"/> No
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Lotions, powders or salves used
 Yes No If "Yes", product name(s) – Specify:

Toilet training attempted
 Yes No If "Yes", describe routine.

Type of toilet seat used at home
 Potty chair Special toilet seat Regular toilet seat

Regular bowel movements
 Yes No How often: _____ Time(s) of day: _____

Toileting problems
 Yes No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family speaks what language – Specify.
 English Other If "Other" – Specify:

Age child began talking	Child speaks in <input type="checkbox"/> Words <input type="checkbox"/> Sentences
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Words used to describe special needs – Specify.

UPDATES

COMFORTING

Does child have a fussy time?

Yes No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

Held Sung to Rocked Read to Other – Specify:

Special things you say or do to comfort child.

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to = (Check all that apply)

Sit up alone Pull up Crawl Walk holding on Walk without support

Yes No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite toys and activities – Specify.

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed

MEDICAL AUTHORIZATION and RELEASE

I hereby authorize/release the Teachers and Director of Mother's Day Out to obtain any necessary medical treatment for my child, _____ (full name) provided the person or persons involved act in good faith to secure any help or treatment my child may require.

My hospital preference is _____. I understand that if I do not indicate a preference that the hospital of choice for Mother's Day Out is Milwaukee County Children's Hospital.

I further understand that the procedure practiced by the staff of Mother's Day Out in the event of an emergency is as follows:

Major Injury/Illness (including but not limited to seizures, substantial loss of blood, convulsions, not breathing, etc.)

Teacher or Director calls 911.

Child is stabilized according to directions from emergency personnel.

Parent is contacted.

If parent can not be contacted, emergency contact person will be called.

Serious Injury (including but not limited to broken bones, need for stitches, etc.)

Child is stabilized.

Parent is contacted.

If parent can not be contacted, the emergency contact person will be notified.

Teacher/Director follows instructions given by parent or emergency contact person.

Mother's
Signature _____ Date _____

Father's
Signature _____ Date _____

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the child care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's care center or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus Influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care center entrance. Children who reach a new age/grade level while attending this child care center must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

- For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

 Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

- For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

 SIGNATURE - Parent, Guardian or Legal Custodian

 Date Signed

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3, and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes (Privacy Law, s.15.04(1)(m), Wisconsin Statutes).

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)
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Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

Yes No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)
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SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination
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Diaper Ointment Application

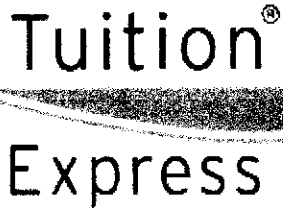
I give permission for the staff of Mother's Day Out Preschool to apply diaper ointment to my child

The ointment I have provided is called _____

Any additional information _____

Parent Signature

Date



We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

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)

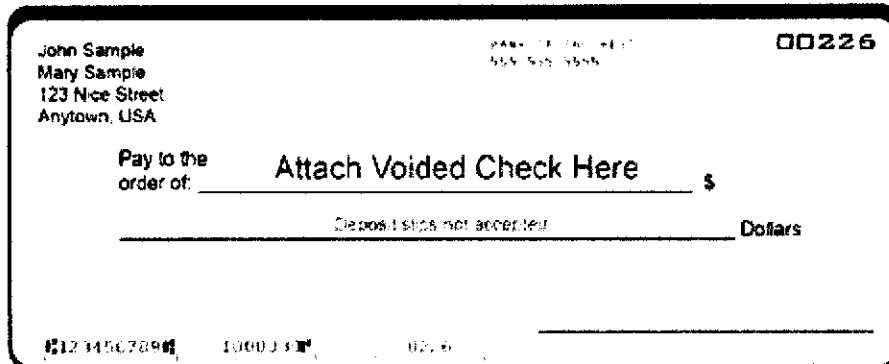
Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

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)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			

For Official Use Only

Date Received
Employee Signature



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All About Me!

MDO TODDLERS



My full name _____ Please call me _____
My birthday _____

I live at _____

I have _____ sisters (names & ages) _____

I have _____ brothers (names & ages) _____

My pet is a _____ My pet's name is _____

I live with _____

Mom and Dad are (please circle): married divorced separated other

Dad's name _____ Things I like to do with Dad _____

Dad's occupation _____ Employer _____

Mom's name _____ Things I like to do with Mom _____

Mom's occupation _____ Employer _____

My family describes me as _____

ALLERGIES? ___YES ___NO

If yes, please explain _____

RECEIVING ANY THERAPY: (i.e. speech therapy, etc.) ___YES ___NO

If yes, please explain _____

If no, are there any concerns _____

My favorite things to do _____

Activities/Trips I did over the summer _____

Any other helpful information _____



EATING HABITS:

My favorite food _____

Any helpful information about my eating habits _____

SLEEP/NAP HABITS:

I usually go to sleep at night around _____ In the morning I usually wake up around _____

I take a nap ___ YES ___ NO

I usually nap about _____ hours

When I sleep, I like (list special comfort item, i.e. nuk, blanket, etc.) _____

Any helpful information about my sleep/nap habits _____

DIAPER HABITS:

Diaper Ointment ___ YES ___ NO

If yes, type _____

Any helpful information about my diaper habits _____

