



# **Elkader Childcare and Learning Center**

## *Enrollment Packet*

117 Gunder Road NE • P.O. Box 667 • Elkader, Iowa 52043  
563-245-3333

*Elkader Childcare and Learning Center is an equal opportunity provider and employer. Applications for enrollment are considered without regard to race, religion, color, gender, national origin, handicapping conditions, or any other basis prohibited by law. Children with special needs will be admitted when the director, local AEA, and /or student's teacher determines the needs of the child can be properly met, without affecting the care of other children attending the Center.*

8/2005



**Elkader Childcare and Learning Center  
General Information Intake Sheet Continued**

**DISCIPLINE**

When you find it necessary to discipline your child, which parent usually does it, and how? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER INFORMATION**

Give any further information that you believe would be helpful in working with your child: \_\_\_\_\_

\_\_\_\_\_

What do you hope your child will gain from this experience? \_\_\_\_\_

\_\_\_\_\_

Is your child adopted?  Yes  No      Does he/she know it?  Yes  No

Does your child need help in:  dressing/undressing     washing     eating     toileting

Does your child receive any services from other agencies such as HAWC, AEA, Headstart, Early Head Start, Department of Human Services, etc...?  Yes  No      If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

For children enrolled in preschool program only: Will your child be riding the bus?  Yes  No

**PAYMENT**

I (we) are responsible for paying the childcare bill every Friday.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Elkader Childcare and Learning Center Permission and Release Form

- Yes    No   I give my permission for my child to leave Elkader Childcare and Learning Center for walks in the neighborhood with a staff member. I also agree to let my child be transported in a vehicle by a licensed driver (child will not be placed in front seat and will be in proper carseats/restraints) or on public transportation when going on a field trip. Parents will be notified in advance of field trips that require transportation. Walks around the neighborhood may be more unplanned events. Both require additional staffing or volunteers.
- Yes    No   I give my consent for my child's name to be with photographed pictures for use by the Center in newspapers or other media.
- Yes    No   I give my consent for my child to be videotaped for use by the Center for staff training purposes.
- Yes    No   I agree to adhere to the policies as outline in the parent Handbook (fee payment, discipline, illness, etc.). I understand that if I fail to follow the policies as outline, it may constitute dismissal from the program.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

***Please put a "NA" (not applicable) by these statements if they do not apply to your child. Please check the following, two of the four need to be checked for children under the age of 2.***

- Elkader Childcare and Learning Center will provide \_\_\_\_\_ formula and whole milk. All children under 2 years of age will be given whole milk. If your physician states that your child under 2 does not need to be on whole milk, they need to sign below.

- DOES NOT** need to be on whole milk.

Name of medical center \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

- To reduce the incidence of SIDS (Sudden Infant Death Syndrome), most doctors recommend infants under the age of 1 to be placed on their backs to sleep. I give my permission for my child to be placed on his/her back to sleep unless otherwise indicated. Special sleeping instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- If your child is to be placed on his/her stomach to sleep, a doctor's signature is needed. If it is due to medical conditions, please indicate what they are. Before signing, parents must be aware of the risks of SIDS when infants are placed on their stomach according to medical studies. We wish to provide the safest care for your child and will only place your child on his/her stomach to sleep if you sign below, understanding the risks of SIDS (Sudden Infant Death Syndrome). We have further information on SIDS and would like to share it and discuss this issue with you prior to signing below.

Medical Center \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Medical conditions we should be aware of \_\_\_\_\_

\_\_\_\_\_

**ELKADER CHILDCARE AND LEARNING CENTER  
PICK-UP PERMISSION FORM**

**I hereby give my permission for my child to leave the center with the following persons named below. *It is the responsibility of the parents to notify the center of any changes.***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Are there any custody, restraining orders or separation issues that we should be aware of? *explain* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list people that **MAY NOT** pick up your child as a result of these custody or restraining orders. Please attach a copy of the applicable custody or restraining order and a picture of the person(s) involved, if possible. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

# Elkader Childcare and Learning Center Parental Emergency Medical Consent Form

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### PARENTS/GUARDIANS WITH WHOM THE CHILD RESIDES:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_

Work phone \_\_\_\_\_ WorkCell Phone \_\_\_\_\_ Work hours \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Work Cell Phone \_\_\_\_\_ Work hours \_\_\_\_\_

### People to contact in case of emergency when parents are unreachable, and are authorized to pick up child from center

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Work hours \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Work hours \_\_\_\_\_

Are there any custody or restraining orders in effect that we should be aware of? If o, please explain and list the people involved that **MAY NOT** pick up your child: \_\_\_\_\_

### PHYSICIANS/DENTISTS/HOSPITALS

*Child's Doctor* \_\_\_\_\_ *Phone* \_\_\_\_\_ *Complete Address* \_\_\_\_\_

*Child's Dentist* \_\_\_\_\_ *Phone* \_\_\_\_\_ *Complete address* \_\_\_\_\_

*Hospital* \_\_\_\_\_ *Phone* \_\_\_\_\_ *Complete address* \_\_\_\_\_

*Known allergies* \_\_\_\_\_ *Present medications* \_\_\_\_\_ *Date of last tetanus* \_\_\_\_\_

*Insurance company* \_\_\_\_\_ *Policy holder ID* \_\_\_\_\_ *Religious preference (optional)* \_\_\_\_\_

In the event that my child (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment at \_\_\_\_\_ Hospital/Clinic and Doctor \_\_\_\_\_ or his/her designee to provide this care. If my child (listed above) may require dental and/or dental surgical care I give consent to \_\_\_\_\_ Clinic/Hospital and Dentist \_\_\_\_\_ or his/her designee to provide this care. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment of my child as secured or authorized under this consent. **Note: Every effort will be made to notify parents/guardians immediately in case of emergency.**

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

**This consent will be effective for 1 year beginning with the date it was signed.  
This form will be presented upon admission for treatment.**

# Iowa Child and Adult Care Food Program Childcare Enrollment Form

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

My infant/child's usual times of attendance will be:

DAYS (please circle): Monday Tuesday Wednesday Thursday Friday

HOURS: Arriving at \_\_\_\_\_ Leaving at \_\_\_\_\_

My infant/child's anticipated meal participation will be:

- Breakfast  AM Snack  Lunch  PM Snack

## Infants (under 1 year of age):

As a participant in a USDA Child Nutrition Program, our Center offers meals to all ages of children. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) for your choice(s) of the following options that will fulfill your infant's food needs in both section A and B. You may have more than one choice.

### A. Breast Milk and/or Formula

- I will provide breast milk for my infant.
- I will provide infant formula for my infant. Name of formula: \_\_\_\_\_
- I accept the Center's formula for my infant. Name of formula: \_\_\_\_\_

### B. Solid Foods (this includes infant cereal)

- I accept the center's solid foods (appropriately textured) to be served to my infant as he/she is ready for them, and after I have discussed it with the caregiver. (The food that the center is providing is Gerber Rice Cereal.)
- I will provide solid foods for my infant.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Elkader Childcare and Learning Center Sunscreen Release

I/We give permission for \_\_\_\_\_ to have sunscreen applied to his/her exposed skin before going outside for any duration of 30 minutes or longer. (We use 45 SPF sunscreen for all children unless otherwise indicated by parents.)

*Special Instructions:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

No, I **DO NOT** want my child to have sunscreen on.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Elkader Childcare and Learning Center Milk Release *(For children under the age of 2)*

Most physicians recommend that children under the age of two be served formula, breast milk, or whole milk.

- We will serve infants up to one year breast milk or formula.
- We will serve children age 1-2 years old breast milk, formula, or whole milk.

**We cannot serve your child anything different than that listed above until this form is signed by you and your physician and returned to the center.**

If your child requires a supplement, please list here: \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's address and phone number: \_\_\_\_\_

**Elkader Childcare and Learning Center**  
**Child File Requirements**

*Elkader Childcare and Learning Center*  
117 Gunder Road NW • P.O. Box 667 • Elkader, Iowa 52043 • 563-245-3333

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Father's name \_\_\_\_\_

Mother's name \_\_\_\_\_

Child Enrollment Packet ..... Dated \_\_\_\_\_

Emergency Medical/Dental Consent Form ..... Dated \_\_\_\_\_

Pick-Up Permission Form ..... Dated \_\_\_\_\_

Physical Examination ..... Dated \_\_\_\_\_

Physical Examination Update ..... Dated \_\_\_\_\_

School Age Physical ..... Dated \_\_\_\_\_

Certificate of Immunization ..... Dated \_\_\_\_\_

Sunscreen Release/Field Trip Permission/Picture Release ..... Dated \_\_\_\_\_

(Infants Only) Milk Release/Infant Food Program/Infant Position Release Form ..... Dated \_\_\_\_\_

Free and Reduced CACFP ..... Dated \_\_\_\_\_

Registration Fee ..... Dated \_\_\_\_\_