CAPITAL KIDS INC.

WELCOME!

We are happy to welcome you to our Capital Kids family! Please know the door is always open for you to visit your child anytime throughout the day. Administration is available for any of your needs or questions. No matter how small, don't hesitate to come see us!

It is our job to make sure your child's stay here is a pleasant one and we want nothing more for you than to enjoy your day knowing your child is well cared for.

Thank you for choosing Capital Kids, we look forward to watching your child grow

with us! Sincerely,

Helen Marinello – Owner
Dominique Cameron - Director
Mary Armbruster - Assistant Director & all Capital Kids Teachers

Required enrollment forms:

- Capital Kids Emergency Contact Information
- Capital Kids Policies and Agreements
- Capital Kids Authorization and Consent Form
- Financial Agreements
- Parent Handbook Acknowledgement
- Diaper Cream Authorization (only if used)
- Sunscreen Authorization (yearly)
- Credit Card authorization form
- D.C. Universal Health Certificate (With immunizations)
- D.C. Oral Health Form (3 years and older)
- OSSE Authorization for Child's ER Medical Treatment
- OSSE Registration Record: Child Receiving Care Away from Home
- OSSE Travel and Activity Authorization

Capital Kids Emergency Contact Information

Child's First and Last Name	Nickname	DOB
Address	City, State	Zip
Chronic Physical Problems/Pertinent Developmental Information		
Known Allergies/Asthma		

Parent(s)/Guardian(s)

Parent Name	Employer	Work Phone
Home Address	Home/Cell Phone	E-mail
Parent Name	Employer	Work Phone
Home Address	Home/Cell Phone	E-mail

Emergency Contacts (Include nearest Relative)

Name	Relation	Pick up Y/N	Phone number
Name	Relation	Pick up Y/N	Phone Number
Name	Relation	Pick up Y/N	Phone Number
Name	Relation	Pick up Y/N	Phone Number

*Appropriate custody papers need to be kept on file if a parent is not allowed to pick up a child. Section 324.2-3 states that unless a court order has been issued to the contrary, the non custodial parent of a child in day care must be included, upon the request of said non custodial parent, as an emergency contact for events occurring during the day care activities.

Policies & Agreements

1. Capital Kids, Inc. agrees to notify the parent or guardian whenever the child becomes ill and the parents or guardians will arrange to have the child picked up within one hour.
2. The parent/guardian agrees to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.
3. Parents/guardians will have no objection to Capital Kids seeking emergency medical care when deemed necessary. Please note; in all cases of an actual emergency, not limited to National Emergency, the parent/guardian will hold harmless the staff of Capital Kids, Inc. if emergency treatment is given by the staff member or emergency personnel. Furthermore, the parent/guardian will be responsible for all cost associated with emergency treatment including, but not limited to transportation; to receive said care.
4. As of 6:01 pm you are officially late. A late fee of $2.00 per minute, per child will be charged for time after 6:00 pm. If no parent/guardian or emergency contact can be reached within 1 hour of center closing, social services and the police will be notified.
5. A 30-day written notice must be given to withdraw from care. **Families will be responsible for one-month tuition if proper notice is not given.**
6. Tuition **will not** be prorated or discounted due to school closing or a child being absent due to illness orvacation.
7. Tuition is due on the first of each month. In the event that a child's tuition becomes past due, child care services will be terminated. Parents/guardians MUST pay the balance in full to re-instate care. Furthermore parents/guardians will be held responsible for any and all fees incurred by Capital Kids Inc. in the collection of such money.
8. Capital Kids, Inc. reserves the right to terminate care at any time due to excessive behavior (i.e. biting, hitting, kicking, inconsolable or anything that endangers him/herself, teachers, or classmates). When possible a notice of 48 hours will be given either by phone, e-mail, or letter from the Director or Owner of Capital Kids.
9. If your child develops any, but not limited to, the following symptoms, he/she will need to be picked up from Capital Kids within one hour:

   Symptoms/diseases: fever- 100◦ or more, severe coughing: high pitched or croupy sounds while coughing, colored discharge for the nose, difficult or rapid breathing, yellowish skin or eyes, symptoms of conjunctivitis (pink eye), unusual spots or rash, vomiting or diarrhea, itching scalp or body, infected or crusty skin patches

   *If any of the above symptoms are present in the morning or the previous night, please keep your child home until they have fully recovered.
10. **Parents/guardians understand that your child cannot attend the school if he/she has any illness that threatens the health of other children. Capital Kids, Inc. abides by Health Department regulations concerning periods of infection. Your child must be fever and symptom free for 24 hours before returning to school after an illness. You understand that prescription medication must be administered to your child at home for 24 hours before he/she can return to school.**

11. Only children with special dietary needs as well as infants may bring food from home. If your child can not eat what is on the USDA approved menu plan, it is the parent's responsibility to provide a suitable alternative. Please label and date the bag lunch to be placed in the kitchen refrigerator.
12. We are a nut sensitive facility. No products containing nuts or nut products may be brought into the school for any reason.
13. All food for birthdays or special occasions must be store bought, with a nutrition labeled clearly attached.
14. You understand that child care services will be terminated under the following but not limited to the reasons listed below:
    -Tuition is two or more weeks past due
    - Repeated failure to pick up your child on time
    - Your child's behavior pattern threatens his/ her own health and safety or threatens the health and safety of the other children/staff
    - **Parents/guardians are no longer supportive of Capital Kids program and become negative and uncooperative in their actions and opinions, which works to undermine the operation of the school.**

15. Capital Kids Inc. will be closed for all Federal holidays and Federal Government snow days. Capital Kids will make every effort to open during inclement weather. Please call the center and check email for information on closings, delayed openings, and/or early closings. Capital Kids reserves the right to close for snow days, teacher work days, and trainings as necessary. Work days will be posted as soon as possible giving as much notice as possible.
16. In the event of a National Emergency, Capital Kids Inc. and staff will follow the emergency action plan and/or police direction. The welfare of the children will come FIRST and then parents/guardians will be notified. Capital Kids will take care of the children by following police direction and will be held harmless by parents/guardians. Capital Kids will do the very best to keep the children safe!
17. When you enroll your child at Capital Kids, Inc. you give up your right to sue Capital Kids, Inc. or any staff member. Instead, any disagreements will be submitted to an arbitration company selected by Capital Kids and the involved party from the local directory. A neutral umpire, chosen by the parent/guardian, will resolve disputes in an informal private proceeding. The decision will be final and binding and cannot be appealed.
18. According to DC Licensing standards, please understand all teachers and support staff are mandated reports and must report all cases of abuse and neglect to Child Protective Services.
19. Capital Kids, Inc. Child Care is an at will service.
20. All information provided to Capital Kids will remain confidential.

I have read and understand the above agreements and policies. I have been given and have read the Parent Handbook. I agree to abide by the policies and agreements set forth for the protection of my child as well as the other children and staff members of Capital Kids, Inc.

Childs' Name: _____

Printed name of parent/guardian: _____

Parent/guardian signature:_____Date:_____

Printed name of parent/guardian: _____

Parent/guardian signature:_____Date:_____

Capital Kids Management:_____Date:_____

Capital Kids, Inc.
Authorization & Consent Form

First Aid Consent

I understand that staff members at Capital Kids, Inc. are trained in basic first aid practices and CPR. I authorize certified staff, to give my child first aid and/or CPR as appropriate until emergency personnel arrive. Furthermore, I agree to hold harmless any staff member attempting to help my child under the Good Samaritan Act.

_____ Initial

Consent to Leave the Premises

I give permission for my child to leave the premises of Capital Kids (no more than 2 blocks away) for outdoor exercise and educational purposes, with the understanding that my child will be accompanied by a staff member at all times. (Library, soccer field, playground, tennis court)

_____ Initial

Photography Consent

I give permission for my child to be photographed at Capital Kids. I give permission for my child's photos to be featured in weekly newsletters that are sent out each week via email to Capital Kids families only. I understand that these pictures can be used for classroom newsletters, social media, Capital Kids website, advertisement/marketing, and printed for art projects. All children that do not have permission for their photo to be used, may be blurred and unrecognizable in group photos and pictures of group events. From time to time, television personnel may interview and tape the center and our classrooms, advance notice will be given.

_____ Initial

Security Monitoring Consent

I understand that Capital Kids, Inc. and the WWF building are monitored by closed circuit cameras 24 hours per day. These videos are kept in the security office for security purposes only, for up to one year.

_____ Initial

Moonlighting & Babysitting

Families using a Capital Kids staff member for services outside of the center release Capital Kids, Inc. from any and all responsibility, repercussions, or expenses incurred from said service. Families attempting to entice a staff member to leave their position of employment at Capital Kids for outside services will be subject to immediate termination of childcare services. Furthermore, a Capital Kids staff member is never allowed to drive a Capital Kids child in their own personal car.

_____ Initial

Child's Name_____DOB _____

Printed Name_____Date _____

Signature _____

Capital Kids, Inc

Schedule of Fees & Financial Agreements

Wait List Fee (one time only, nonrefundable)	$350
Registration Fee (per child, nonrefundable)	$350
Ages 12 weeks - 2 years & 5 months	$2452 monthly
Ages 2 years 6 months - 5 years	$1990 monthly

1. A one month, non-refundable deposit is required to hold your space until you start care.
2. When you are brought in off of the wait list, your wait list fee covers your registration fee.
3. Tuition is due on the first of each month.
4. Tuition is payable by Visa, American Express or Master Card.
5. There are NO discounts or prorates applied to tuition because of school closings, holidays, illness, or vacation.
6. If tuition becomes two or more weeks past due, child care will be terminated.
7. Parents/guardians are responsible for any and all fees incurred by Capital Kids, Inc. in an attempt to collect payment.
8. A thirty-day written notice must be given in order to withdraw from care. Families will be responsible for one month of tuition if proper notice is not received.
9. Tuition is subject to change at any time.
10. Other charges that will incur are selective items such as; activity fees, holiday fees, field trips and in house events

I have read and understand Capital Kids, Inc. schedule of fees and financial agreements. I agree to abide by them for the duration of services provided by Capital Kids, Inc.

Printed Name_____ Signature_____ Date _____

Printed Name_____ Signature_____ Date _____

Capital Kids Child Development Center
Parent Handbook Acknowledgement

I,_____, acknowledge that I have received a copy of the Capital Kids Parent Handbook. I recognize that it is my responsibility to be informed and comply with the policies, provisions,and procedures it contains.

In addition, I understand that the contents of the Parent Handbook are guidelines that can be modified by the Center if necessary. Iacknowledge that the Parent Handbook will be revised in accordance with the rulesand regulations of state, federal, and accrediting entities. I recognizethat any such revisions will supersede, modify, or eliminate the current contents of the Parent Handbook.

The handbook can be found on the Capital Kids website at www.capitalkidsinc.org. In the event that I would need a hard copy of the Parent Handbook, I understand that I can obtain an updated version upon request to Capital Kids. Moreover, I recognize that it is myresponsibility to contact administration for any questions I might have about thecontents of the Parent Handbook now and in the future.

Printed Name_____ Signature _____ Date _____

Printed Name_____ Signature _____ Date _____

Child Registered (1)_____Child Registered (2) _____

Child Registered (3)_____Child Registered (4) _____

Administration Signature:_____Date:

_____

Date hard copy provided: _____

Administration Signature: _____

Parent Signature: _____

Handbook Revisions:
June 16, 2017

Diaper Cream Authorization Form

Child's Name_____DOB _____

Name of Ointment _____

To Be Applied _____

Effective Date_____Expiration Date _____

This form must be updated every year at minimum.

I understand that it is the responsibility of the parent to maintain an adequate supply of diaper cream at Capital Kids for my child. Provided ointment is for the above specified child ONLY and may not be shared with any other children.

By signing below, I grant permission for Capital Kids, Inc. staff to apply the above noted ointment at times stated above.

Parents Signature_____Date _____

Printed Name _____

Sunscreen Authorization:

Child's Name: _____

Name of Sunscreen: _____

Expiration Date of Sunscreen: _____

Application period: (circle one) Each time outside only once per day

Any reaction to sunscreen?
Explain:_____

_____

I understand that it is the responsibility of the parent to maintain an adequate supply of sunscreen at Capital Kids. Provided sunscreen is for the above specified child ONLY and may not be shared with any other children.

By signing below, I grant permission for Capital Kids, Inc. staff to apply the above noted sunscreen to my child at times stated above.

Parents Signature_____Date _____

Printed Name _____

Insect Repellent/Bug Band:

Name/Brand of Insect Repellent (Bug Band) _____

Expiration Date_____

Any reaction to the repellant? Explain_____

I understand that it is the responsibility of the parent to maintain an adequate supply of Insect Repellent at Capital Kids. Provided Insect Repellent/Bug Bands is for the above specified child ONLY and may not be shared with any other children.

By signing below, I grant permission for Capital Kids, Inc. staff to apply the above noted Insect Repellent to my child while outside.

Parents Signature_____Date _____

Printed Name _____

Credit Card Authorization

Total Amount (Tuition)_____Card Type _____

Credit Card Number _____

Expiration Date_____ Authorization Code _____

Name on Card _____

Billing Address _____

_____

Email for receipt of payments _____

Card to be Charged (Please Circle) Weekly Monthly Yearly Once/Wait List

Beginning_____/_____/20__

By signing below, I authorize Capital Kids, Inc to charge my account as stated above. I understand that I must provide written notification two weeks in advance to stop charges to my account.

Signature_____ Date _____

Name of Child & DOB receiving care _____

(Authorized User Only) Notes/Charges:

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)* ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer		
Race: *(check all that apply)* ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer		
Parent First Name:	**Parent Last Name:**	**Parent Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____/____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Development
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney Failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:** _____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

~~TB Assessment~~ | ~~Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.~~

What is the child's risk level for TB? ❑ High 👁 *complete skin test and/or Quantiferon test* ❑ Low	**Skin Test Date:**	**Quantiferon Test Date:**
	Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated	
	Quantiferon Results: ❑ Negative ❑ Positive ❑ Positive, Treated	
Additional notes on TB test:		

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**		**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**		**2nd Serum/Finger Stick Lead Level:**
HGB/HCT Test Date:		**HGB/HCT Result:**		

Part 3: Immunization Information | To be completed by licensed health care provider.

Immunizations	Provide in the boxes below the dates of Immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year):				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				

❑ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ❑ No ❑ Yes

This child is cleared for **competitive sports.** Additional clearance(s) needed from: _____ ❑ N/A ❑ No ❑ Yes ❑ Yes, pending additional clearance

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	**Provider Name:**
	Provider Phone:
	Provider Signature:
	Date:

Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	**Signature:**	**Date:**
Health Suite Personnel Name:	**Signature:**	**Date:**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*)

Home Zip Code

School Grade

Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant?**	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up? (Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____ Dental Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child_____, born on_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caretaker

_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder:_____ Relationship to Child: _____

Policy Number:_____ Coverage: _____

Medicaid Number:_____State: ___DC ___MD ___VA

Child's Known Allergies or Physical Conditions: _____

_____

Signature: _____Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

Date: _____Date Updated: _____
Month/Day/Year Month/Day/Year

NOTE: Place on file in child's folder/record

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home #: _____ Language Spoken AtHome _____

Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

Date of Withdrawal: _____ **Reason:** _____

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

PHONE: (202) 727-1839•FAX: (202) 741-5304 MAILING ADDRESS: 810 FIRST STREET, NE•4th FLOOR•WASHINGTON DC 20002

PLEASE TYPE OR PRINT

TRAVEL AND ACTIVITY AUTHORIZATION

☐ Special 1-time permission for thisactivity only ☐ Blanket permission for all given activities

I,_____parent/guardian of
Name of Parent/Guardian

_____give my permission to
Name of Child

_____for my child toparticipate in the following activities:

Trips in the van/automobile (facility or parent -owned)

N/A
_____
Explain planned activity — where and when

Field trips away from the facility

Walking to the tennis courts & walking around the block

_____
Explain planned activity — where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility, I
☐ **will allow my child to play outside the fenced area; or _____**
☐ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to One year from enrollment

_____ _____
Parent/Guardian Signature Date Signed

NOTE: Place on file in child's folder/record

Infant's
First Day Checklist

Please bring the following supplies for the day:

- Food/Formula as needed
- Bottles (Clearly labeled with child's name)
- Nursery Water (if necessary)

A clean bottle is required for each feeding We do not wash bottles on site*

Please bring the following supplies for the week:

- Diapers
- Wipes (in wipe box)
- 2 crib sheets & blankets, swaddles if needed
- Several extra outfits
- Bibs
- Diaper Cream
- Pacifier (if needed)

Toddler's (Monkey & Frog Class)
First Day Checklist

Please bring the following supplies for the day:

- Sippy Cup for water (Clearly labeled)
- Sippy cup or bottle for milk
- Sweater/coat/gloves/hat (depending on weather)
- Must have shoes for outside

Please bring the following supplies for the week:

- Diapers
- Wipes
- Diaper cream
- crib sheet & blanket for cot
- Extra outfits
- Diaper Cream

Preschooler's (Puppy & Pony class)
First Day Checklist

Please bring the following supplies for the day:

- Pull-Ups (if necessary)
- Wipes or flushable wipes (if necessary)
- 1 crib sheet & blanket for cot
- Extra outfits/ underwear
- Water bottle
- Back pack
- Sweater/coat/gloves/hat (depending on weather)

bathroom items are stored in child's bathroom bin and used as needed

Pre-Kindergarten (Robin class)
First Day Checklist

Please bring the following supplies for the day:

- Flushable wipes (if necessary)
- 1 crib sheet & blanket for cot
- Extra outfits/ underwear
- Water bottle
- Back pack
- Sweater/coat/glovs/ hat (depending on weather)

All classes:

Please remember to clearly label all of your child's belongings with their first and last name.