Ages 6 week - 4 year old Registration Packet

We are honored that you chose to enroll your child in Great Plays. We are excited to serve you and strive to provide a fun, enriching and stimulating early learning experience for your child. Before we consider your registration complete, we will need the items listed below to register your child. Most of these forms can be found in this Registration Packet. ALL line items must be completed. An incomplete registration packet may result in you forfeiting your classroom spot.

_ Signed School Release Form
_ Emergency Contact & Medical Information Form (completed)
_ Family & Social History form (completed)
_ Non-refundable Registration Fee

The following must be provided no later than September 1 in order for your child to continue to attend:

_ A Physical Evaluation record, to have been performed and signed by a licensed physician or designee, and having taken place within the preceding year.
_ Current immunization Record signed by a representative from your medical provider.

SCHOOL RELEASE FORM:

Great plays students may be photographed or videotaped, and their name and/or work displayed for educational and/or not-for-profit use in various ways; newspaper articles, school newsletters, building videos, school website, etc. lf you do NOT want your child to participate in the above activities you must submit your request in writing to the Program Director by the first day your child attends the center.

Child's Full Name_____Date_____

SUNSCREEN APPLICATION RELEASE & POLICY

Children at Great Plays Daycare will often be outside at peak sunlight hours. With specified permissions, and upon providing an individual sunscreen product, the staff will apply sunscreen to your child. Sunscreen will only be applied to exposed areas of the body, including the face, tops of ears, nose, bare shoulders, arms and legs. I have read the options below and marked my preference.

_ I do NOT wish to have sunscreen applied to my child while at Great Plays Daycare.

_ I give permission to Great Plays Daycare to apply sunscreen to my child with the product that I have/will provide at regular intervals.

INSECT REPELLANT APPLICATION RELEASE & POLICY

Children at Great Plays Daycare will often be outside, and in contact with insects that may bite. With specified permissions, and upon providing an individual insect repellant product, the staff will apply insect repellant to exposed areas of your child's body, including ttte fabe, tops of ears, nose, bare shoulders, arms and legs. I have reviewed the options below and marked my preference.

_ I do NOT wish to have insect repellant applied to my child while at Great Plays Daycare.

_ I give permission to Great Plays Daycare to apply insect repellant to my child with the product that I have/will provide at regular intervals.

Parent's Signature_____Date_____

Staff Initials_____

----------Office Use Only----------

( ) Emergency Medical Form
( ) Physical Examination
( ) Current Immunization Record
( ) Family/Social Information Sheet
( ) Non-Refundable Registration Fee

PHYSICAL EXAM FORM

(Families may use this form OR one from their physicians office.)

A physical must be **signed and dated** by a physician or designee and turned into Great Plays on or before the first day of attending the program and every year thereafter as required by the Department of Human Services. We understand that a physical will not be administered less than 365 days from the last physical. This form is required for your child to participate in our program.

Child's Full Name:_____ DOB:_____

Address:_____
Street City State Zip

Height:_____ Weight:_____

Skin:_____ Head and Scalp:_____

Eyes:_____ Nose:_____ Lymph Nodes:_____

Ears:_____ (L) TM_____ (R) TM_____

Mouth:_____ Gingivia:_____ Palate:_____

Throat:_____ Neck: _____Chest:_____

Heart:_____ BP:_____ Femoral Pulse:_____

Lungs:_____ Abdomen:_____

Spine/Back:_____ Extremities:_____

Neuromuscular:_____ Gait:_____

Vision:_____ (R) Eye:_____ (L) Eye:_____ Both:_____

Hearing: Normal:_____ Abnormal:_____ Not Tested:_____

lf needed: Hemoglobin or Hematocrit: _____ Tuberculin Screening:_____

Sickle Cell Screening:_____ Development Screening:_____

Lead Screening:_____ Other:_____

Allergies:_____

Summary of findings and recommendations: I have examined_____
and find that he/she is physically and emotionally able to participate in programming.

Signature of Physician or Designee: _____Date of Exam:_____

Family & Social History Form

Child's Full Name:_____ DOB:_____

In order to help the teachers to know a little bit about your child, please take a few minutes to complete this Family & Social History form and return it with your Registration Packet.

Does your child have any Food/Environmental/Medicine Allergies _____YES _____UNKNOWN

lf yes, please list:_____
*If an allergy is identified, we will be contacting you shortly to request a health plan. This health plan is in place so that all the

staff know the proper actions to take if your child comes in contact with their allergen. We must have a health plan in place for all allergies except medication allergies.

Does your child have a nickname?_____

Parent's marital status _ Married _ Single _ Divorced _ Widowed _ Remarried partner

Who does the child live with _ Mom _ Dad _ Both _ Grandparents _ Other

Primary language spoken in the home:_____ Secondary:_____

Child's Ethnicity:_____

Does your child currently nap or rest during the day? _ YES _ No lf yes, how long?_____

Does your child use the restroom independently? _ YES _ No
(not a program requirement)

Does your child experience any toileting difficulties? _ YES _ No
lf yes, please explain:_____

Does your child wear a pull-up? _ Day _ Night _ Diapers

What type of toys does your child enjoy playing with?

_____

Has your child been in another preschool, daycare or play group? _ YES _ No Group size? _____

Describe your child's previous group care experience: _____

_____

Does he/she accept new people/activities easily? _ YES _ No
lf no, please explain:_____

What are your child's fears?_____

What does your child especially enjoy?_____

_____

Has your child experienced any of the following:

_ Asthma/Wheezing

_ Heart Disorder

_ Kidney/Bladder

_ Scarlet Fever

_ Mumps

_ Chicken Pox

_ Other

If yes to any of the above, please elaborate on each condition:_____
_____
_____

Has your child experienced any of the following:

_ Nose Bleeding

_ Seizures

_ Fainting

_ Medications

_ Eczema/Dry Skin

_ Other

If yes to any of the above, please elaborate on each condition:_____
_____
_____

Please list any siblings name's and their ages below:
_____
_____
_____

What do you hope for your child to gain from our program(s) this year at Great Plays?
_____
_____
_____
_____

Please give any further information which you believe will be helpful to best understand how we can partner together in caring for your child (topics to include may be temperament, toileting, sleeping, eating, family, etc.):
_____
_____
_____
_____

Parent Signature: _____Date:_____

GREAT PLAYS

EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

_____	_____ **M F**
Child's Name	Date of Birth Sex
_____	_____
Parent/Guardian's Name	Parent/Guardian's Name

Primary Phone	Work Phone	Primary Phone	Work Phone
Street Address		Street Address	
City, State, Zip Code		City, State, Zip Code	
Employer		Employer	
Daytime Contact 1 (Name & Number)		Daytime Contact 2 (Name & Number)	
Primary Email Address *Billing Statements and correspondence will be sent to this address		Secondary Email Address	

Alternative Emergency Contacts
(in addition to parents)

Primary Emergency Contact		Secondary Emergency Contact	
Primary Phone	Work Phone	Primary Phone	Work Phone
Street Address		Street Address	
City, State, Zip Code		City, State, Zip Code	

MEDICAL INFORMATION

Hospital/Clinic Preference

Physician's Name

Phone Number

Physician's Address _____ Date of Last Visit _____

Insurance Company _____ Policy Number _____

Dentist's Name _____ Phone number _____

Dentist's Address _____ Date of Last Visit _____

Insurance Company _____ Policy Number _____

Allergies/Special Health Considerations _____

I authorize all medical and surgical treatment, X-Ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waived my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of emergency.

Parent's/Guardian's Signature _____ Date _____

I give permission for my child to go on field trips. I release Great Plays and individuals from liability in case of accident during activities related to Great Plays as long as normal safety procedures have been taken.

Parent's/Guardian's Signature _____ Date _____

Staff Signature _____ Date _____

Pick-Up Permission List

Child's Full Name:_____

I, _____ , hereby give permission for my child to leave Great Plays with the following persons named below.

NAME	CONTACT NUMBER	RELATIONSHIP

I understand that it is my responsibility to notify Great Plays of any changes to this form.

_____ _____

Parent's/Guardian's Signature Date

_____ _____

Staff Signature Date

Your child is enrolled in a center that participates in the Child and Adult Care Food program (CACFP). By participating in this program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

Iowa Child Adult Care Food Program

Child Care Enrollment Form

Times of Care	Regular Days of Care	Meals Served During Care	Ethnicity/Race

Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	TH	F	S	S	B	AM SN	Lu	PM SN	D	E SN	Ethnicity	Rac

*Ethnicity (Select one and enter in the chart above): H= Hispanic or Latino or N= Not Hispanic of Latino

*Race (Select one of more and enter in the chart above): W= White, B= Black or African American, I= American Indian or Alaska Native, A= Asian, and P= Native Hawaiian or Other Pacific Islander. This information is requested by the Federal Government in order to monitor compliance with Civil Rights Laws. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note on the basis of visual observation.

Infants Only (0 to 12 months): _ I am not enrolling an infant (skip this section)

As a participant in the USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

_ I will provide breastmilk for my infant. _Yes _No Centers formula may be used to supplement feeding if necessary _Yes _No

_ I would like to breastfeed onsite, if the option available[1] _ Yes _No

Yes, time(s0_____

_ I will provide formula for my infant. Name of formula (must be iron-fortified formula and manufactured in the USA):_____

_ I accept the center's formula for my infant. Name of iron-fortified formula:_____

_ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula:_____

_ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

_ I will provide solid foods for my infant[2]. The center my supplement with additional solid foods when my infant needs them

_ Yes _ No

Parent Signature_____ Date:_____

Parent Signature_____ Date:_____(Make any needed changes above, sign and date)

Parent Signature_____ Date:_____(Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal