

## CHILD CARE AGREEMENT-Little Learners, Too

Date: \_\_\_\_\_

Child Name: \_\_\_\_\_ DOB \_\_\_\_\_

Child Name: \_\_\_\_\_ DOB \_\_\_\_\_

Child Name: \_\_\_\_\_ DOB \_\_\_\_\_

Mealtimes are; Snack 9am, and 3:00pm. All children must be in attendance at the start of the meal. No food or beverages should be brought to the facility unless advanced arrangements are made. Refer to handbook for more specifics. \*meals may be suspended based on, but not limited to availability, staffing, local/state/national crisis, etc.

**CARE HOURS ARE BASED ON WHAT IS WRITTEN IN THIS AGREEMENT. HOURS ARE BASED ON CONTRACTED HOURS OF CARE, NOT WHEN THE CENTER OPENS AND CLOSES. LATE FEES BEGIN 1 MIN AFTER YOUR AGREED UPON TIMES AND FRIDAYS ARE DOUBLED.**

It is agreed that the owner, administrator any employee or staff member will be held liable for any injury to your child/children while in attendance. You, the parent/guardian, are responsible for any and all medical bills incurred for medical treatment for your child. In the event of emergency, the State of Ohio Emergency Transportation Authorization form, will be relied upon for direction.

**PRIVATE PAYMENT;** Age Group \_\_\_\_\_ Payment due weekly at drop off\$ \_\_\_\_\_

Age Group \_\_\_\_\_ Payment due weekly at drop off\$ \_\_\_\_\_

I/we agree to pay monthly counting Sundays in the month \_\_\_\_\_ (Initials here)Disc. Discussed in handbook

**ODJFS PAYMENT;** Age Group \_\_\_\_\_ CoPayment due weekly at drop off\$ \_\_\_\_\_

Age Group \_\_\_\_\_ CoPayment due weekly at drop off\$ \_\_\_\_\_

Age Group \_\_\_\_\_ CoPayment due weekly at drop off\$ \_\_\_\_\_

I/we agree to pay monthly counting Sundays in the month \_\_\_\_\_ (Initials here)No disc offered for ODJFS

Registration, late fees and other fees apply. Refer to the Policy Handbook.

### PARENTAL/GUARDIAN RESPONSIBILITIES

- To allow staff members to discipline according to the State of Ohio Guidelines regarding discipline in a childcare setting. Redirection or timeout will be the main form used.
- Actively participate in the daily activities of your child/children including but not limited to, reading literature and communication from the Provider daily, communicate via text, email, phone, conferences, etc. to discuss concerns, ask questions and give feedback.
- Attend an annual conference, phone discussion or choose to have documents on your child's development sent home with you. This information will include discussion of developmental milestones/goals, concerns, and constructive feedback on how we can work collaboratively. This also includes any renewal of agreements/documents, etc. needed for a smooth annual transition. These are non inclusive
- Communicate in a respectful manner at all times and schedule a private conference if needed for further discussions.
- Pay all tuition, copays, and fees charged when incurred.
- Be sure your child has a good night sleep and will come to school dressed and ready to participate.
- Do not bring your child to school if they violate the illness policy. If an illness is in question, the Provider will make the final decision regarding participation taking into consideration the needs of your child as well as the others and the needs of the caregivers.
- Send extra clothing for accidents, snow play.
- Notify the Program in writing of contractual changes, address or phone changes, etc.
- Only those stated on Child Enrollment form as emergency contacts, will be permitted to pick up your children. In the case of custody or divorce, I must have a copy of the documents outlining visitation agreements.

- Supply the Provider with all necessary dietary supplements such as but not limited to infant formula/breastmilk, soy/lactose free milks, etc. when restrictions apply. \*documents necessary at times
- All families must submit a work schedule weekly, biweekly or monthly for all variable schedules and/or college schedule each semester. This helps the Provider plan for employee work schedules and keep in ratio with the licensing rules.
- **All care hours are based on what is written in this agreement. Late fees are based on 1 min after your agreed upon pickup time. \*Hours based on contracted hours, NOT center closing time.**

#### TERMINATION/WITHDRAWALS

This agreement has a 30-day trial period(new clients/agreements only, not including renewals or changes) in which the parent or Provider can cancel at any time during this period, without notice or explanation. No refunds on tuitions or fees paid will be issued. Trial period starts from the date on the Child Care Agreement. After the trial period, this agreement can be terminated immediately or at any time if attempts to rectify a situation haven't been successful by either parent or Provider. No refunds on tuition or fees or days not used will be issued. This agreement can be terminated by Provider or parent if one, some or all of the agreements set forth in the Childcare Agreement and/or Policy and Procedures Handbook, haven't been met. No refunds on tuition and/or fees paid, or days not used will be issued. The advance notice of **two weeks** is required for all families for all other reasons such as but not limited to; change of residence, situation changes such as divorce, job change/loss, family dynamics, change of Providers, work schedule changes, change of hours, status of full-time/part-time, tuition changes, etc.

**\*\*Note;** if 2 weeks written notice is not given and /or attempts to reach the parent/guardian has failed upon extended absences, the parent/guardian will be billed/charged the tuition rate set forth in the Agreement for two weeks and the county dept. of Job and Family Services plus copays for the care of your child for two weeks. It is in your best interest to give the proper and respectful 2 weeks advance written notice if you intend to leave the facility. Outstanding balances are explained in the Policy Handbook.

Parent/guardian sign \_\_\_\_\_ Provider/Admin \_\_\_\_\_

#### HOURS OF CARE

I, \_\_\_\_\_ (parent/guardian) Can use childcare during the following hours and days for my child/children. If variable(county families) I will send a work and/or school schedule via email, text or paper copy weekly, biweekly or monthly whichever applies, to my Provider so she can plan for staffing for ratio compliance. I understand The facility hours are different from the hours I can use below for childcare.

Monday _____ to _____	Schoolage	Monday _____ to _____
Tuesday _____ to _____		Tuesday _____ to _____
Wed. _____ to _____		Wed. _____ to _____
Thurs. _____ to _____		Thurs. _____ to _____
Friday _____ to _____		Friday _____ to _____

These are my agreed upon hours and days and anytime earlier or later will result in additional fees set forth by the Provider. I understand these fees are not covered by the ODJFS copay or private tuition payments and/or supply/registration fees. I am responsible for full cash payment within 24 hours(or date agreed upon by both parties) that they are incurred or termination of my childcare may occur. Please note that all families receiving public assistance, are required to use childcare for work or school hours plus one hour travel time to and from work/school, in this facility.

\_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Ohio Department of Children and Youth  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home
Home Address				City
State	Zip Code	Home Telephone Number		
Parent/Guardian Name #1			Relationship to Child	
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone (if applicable)		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
<p>Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email</p> <p>Where can you be reached while your child is in this program/home?</p>				
Parent/Guardian Name #2		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
<p>Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email</p> <p>Where can you be reached while your child is in this program/home?</p>				
<p><b>Emergency Contacts:</b> Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness <u>if you cannot be reached</u>. Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</p>				
Name		Name		
City		State	City	
Telephone Number	Relationship to Child		Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)	
Name of Physician or Clinic/Hospital				
Street Address				
City		State	Telephone Number	

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (check all that apply)

No

Yes - check all that apply

Food

Medication

Environmental

Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (check one)

No

Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (check one)

No

Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (check one)

No

Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (check one)

No

Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

No

Yes - a DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (check one)

No

Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

No

Yes - written instructions from the child's health care provider must be on file.

N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name

### Diapering Statement

Is your child toilet trained?  Yes (If yes, skip to Emergency Transportation Authorization section)  
 No (If no, fill out the following:)

The program's policy is to check diapers every \_\_\_\_\_ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule       I do not agree, please check my child's diaper every \_\_\_\_\_ hours.

### Emergency Transportation Authorization

<u>Give Permission to Transport</u>		<u>Do Not Give Permission to Transport</u>	
Program or Home Name		Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date	Parent's Signature	Date

### Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook.  Yes  No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initiated and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

**Reset Form**

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
<b>Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):</b>	
<b>Section A- EXAMINATION</b>	
<input checked="" type="checkbox"/> The above named child has been examined. <input checked="" type="checkbox"/> The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care). <input checked="" type="checkbox"/> The above named child does not have allergies OR is allergic to the following ( <i>please list in space below</i> ): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	
<i>Check below, if applicable:</i> <input type="checkbox"/> Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.	
Optional: Measurements and Recommended Assessments/Screenings Height _____ Vision _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Weight _____ Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No BMI _____ Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Notes:	
Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner _____ Telephone Number _____	
Street Address _____ City, State and Zip Code _____	
<b>ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.</b>	
<b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b> <b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b> Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
<b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b> <input type="checkbox"/> The above named child has been immunized against the diseases listed above. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	Initials of Examining Health Care Practitioner <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> Date
<b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b> <input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Signature of Parent <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> Date

Ohio Department of Job and Family Services  
**BASIC INFANT INFORMATION FOR CHILD CARE**

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.					
Child's Name	Nickname				
Child's Date of Birth	Siblings				
<p>What are you feeding your infant? <i>(Check all that apply)</i></p> <input type="checkbox"/> Formula (include brand) <input type="checkbox"/> Breast milk					
Formula preparation <i>(if center/provider is to prepare.)</i>					
Amount for each feeding	Frequency of feedings				
<p>My infant likes a bottle warmed: <i>(Check one)</i></p> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT					
Juice <i>(type, amount, when?)</i>					
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <small>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</small>					
Are foods served room temperature or warmed?					
Table food <i>(types, amounts, frequency, special instructions)</i>					
Security items <i>(pacifier, blankies, etc.)</i>					
Nap schedule					
Hints for getting baby to sleep					
<p>Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy*</p> <small>*You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.</small>					
Special Precautions					
Any additional information about your child that would be helpful or you would like staff to know.					
Parent Signature					
Primary Caregiver Signature					
Date form last updated					



## MINOR CHILD PHOTO/MEDIA RELEASE FORM

I, \_\_\_\_\_ the Parent/legal guardian of, \_\_\_\_\_

Hereby grant LITTLE LEARNER'S, TOO and any third party whom LITTLE LEARNER'S deems appropriate, my permission to use photographs, videos or other media, for any legal use, including but not limited to: social media, television, publicity, advertising and web content.

Furthermore, I understand that no royalty, compensation or fee shall be paid for said use. This release shall be valid until revoked in writing.

\_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date

\_\_\_\_\_ Parent/Guardian Printed Name

\_\_\_\_\_ Child/Children Names

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

## LITTLE LEARNERS TOO CHILDCARE ILLNESS POLICY

When a child arrives for care, they must be in good health and free from symptoms of contagious disease, or according to state law, they must be refused admittance. Symptoms of contagious disease can be, but not limited to; unexplained rash, earache, vomiting, swollen glands, sore throat, difficulty swallowing, running-discharge from eyes-pink eyes, excessive coughing(child cannot stop, gags, turns red or bluish in face or vomits from the cough), 2 or more bouts of diarrhea or abnormal stools for that child in 24 hour period, fever greater than 100.0 degrees F present in last 24 hours, unusual sleepiness, etc. the child must be capable of full participation. Sometimes the actions themselves may be case enough to keep them home if they cannot endure a full, busy, active day at school.

When your child is diagnosed with any of above or with a contagious disease or any illness requiring the use of antibiotics or prescribed medication, they must be kept home for 24 hours after the start of the prescribed medications. The parent/guardian is also required to report ANY contagious illness to the program within 12 hours of diagnosis. At the discretion of the Program Administrator, a dr. note MAY be required for return to the facility. Do not give your child ibuprofen or advil and send them to the facility, if you have to do that, there's a problem(Doesn't include teething infants). \*In the event there is a question regarding the participation of your child at the facility, the Program Administrator will be the person to make the final decision, taking into consideration licensing rules, Little Learners specific rules, child's actions, length or severity of illness, etc. Return to facility can occur when child is symptom free for minimum of 24 hours without the use of any medications. \*updated guidance from CDC for Covid 19 is followed.

Medications; No Over counter meds will be administered at all. Only Prescribed medications 3x daily can be sent to facility to administer the afternoon dose. Dose 1&3 will be administered at home.

If your child becomes ill while in the care of Little Learners Too, we will;

1. isolate child in a comfortable, visible area in crib or cot
2. notify parent/guardian/backups listed in jfs01234 immediately
3. require child/children to be picked up within 1 hour of the original call/text.

Upon enrollment, it is agreed that this is the illness policy set forth and any family actively enrolled will follow said policy.

WEBBERS KIDS LLC  
36721 LAKESHORE BLVD.  
EASTLAKE, OH 44095

## Appendix B to Rule 5101:2-12-16

**Caring for Sick Children**

A child is considered to be sick when demonstrating any of the following symptoms:

- Temperature of at least one hundred and one degrees Fahrenheit (one hundred degrees Fahrenheit if taken axillary) when in combination with any other sign or symptom of illness.
- Diarrhea (three or more abnormally, unexpectedly or unexplained loose stools within a twenty-four hour period).
- Severe coughing, causing the child to become red or blue in the face or to make a whooping sound.
- Difficult or rapid breathing.
- Yellowish skin or eyes.
- Redness of the eye or eyelid, thick and purulent (pus) eye discharge, matted eyelashes, burning, itching or eye pain.
- Untreated infected skin patches, unusual spots or rashes.
- Unusually dark urine and /or gray or white stool.
- Stiff neck with elevated temperature.
- Evidence of untreated lice, scabies, or other parasitic infestations.
- Sore throat or difficulty in swallowing.
- Vomiting more than one time or when accompanied by any other sign or symptom of illness.

When caring for sick children, the center shall:

- Isolate the sick child away from other children in another room or portion of a room, but within sight and hearing at all times.
- Provide the sick child with a cot or mat or the sick infant with a crib, and make comfortable.
- Notify the child's parent(s) immediately to arrange discharge and if the child's condition worsens during isolation.
- Sanitize the thermometer after each use.

## FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

***We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL***

Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

Child's/Children's Name(s):	Caretaker's Name:	Date Completed:
TOPICS	Briefly List CONCERN	
<b>Child Development and Education-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Information on child growth and development.
Y	N	Guiding and supporting a child's behavior.
Y	N	Medical or disabilities or possible conditions for any child or adult in the family.
Y	N	Obtaining toys or activities to use to help any child in your home.
Y	N	Preparing your child for kindergarten.
<b>Child and Family Health-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Health insurance and/or access to regular medical care, dental care, or medications.
Y	N	Medical or health supplies or supports that anyone in your family needs.
Y	N	Accessing immunizations.
Y	N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.
Y	N	Concerns with depression, anger, anxiety, or mental health needs.
Y	N	Concerns with alcohol, drug, or addiction problems.
<b>Financial and Household Supports-</b> Does anyone in your family have any need for resources or support in the areas listed below?		
Y	N	Help paying for child care.
Y	N	Help finding housing or safe housing.
Y	N	Help paying your mortgage or rent.
Y	N	Help with food expenses.
Y	N	Finding household items such as furniture, clothing, or school supplies.
Y	N	Access to transportation or transportation expenses.
Y	N	Attending school (such as a GED, Certifications, or college degrees)
Y	N	Help finding work or job training

Are there other needs you or your family have that are not listed above:

Parent Signature		Date:
Administrator or Designee Signature:		Date:
For Staff Use:		
Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
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**Ohio Department of Job and Family Services**  
**FAMILY INFORMATION**  
**FOR STEP UP TO QUALITY PROGRAMS (SUTQ)**

Child's Name (Last)	(First)	Nickname (if any)
<p><b>By providing accurate information about your child, you will be assisting us in creating a positive environment for him/her while in care. Let any information about your child's habits, allergies or preferences that you feel will be helpful to us and when caring for your child.</b></p>		
<p>Who is in the child's immediate family?</p>		
<p>Who lives at home with your child?</p>		
<p>What is the primary language spoken in your child's home?</p>		
<p>Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?</p>		
<p>Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?</p>		
<p>Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)</p>		
<p>Do you have any pets at home? If so, what are they and what are their names?</p>		
<p>Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)</p>		
<p>My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. (Check all that apply)          How much and how often?</p>		
<p>Does your child have any favorite foods?</p>		
<p>Does your child dislike any foods?</p>		
<p>Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)</p>		

Please check **all** of the words that best describe your child's personality and behavior.

- active  adventurous  affectionate  anxious  bossy  bright  busy  calm  cautious  cheerful  
 content  creative  curious  easily-angered  emotional  energetic  excitable  friendly  gives-in-easily  
 happy  hesitant  insecure  jealous  likes structure/routines  loud  loving  mellow  outgoing  
 prefers adult attention  quiet  sensitive  serious  shares-well  social  spontaneous  stubborn  tentative  
 other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a  high chair,  booster,  child size chair or  adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date