# School Dist # 17H & 1
# Child Care Facility

601 N. Terry
Hardin, MT 59034

2019-2020 Enrollment Application

406-665-6458

## Child's Information:

**Last**_____ **First**_____ **Middle**_____

**Nickname** _____ **Age**_____

**Address**_____**City**_____**ST**___**Zip**_____

**With whom does child reside?**_____

**Who else lives in the home ( siblings, extended family, pets)?**_____

**Are there words/phrases in home language that we should know?**_____

**Are there cultural or family customs, rituals, or traditions that will help us make your child's experience more meaningful?**_____

## Child Information

**Age child began: sitting**_____ **crawling**_____ **walking**_____ **talking**_____

**Does child: sit up**_____ **pull up**_____ **crawl**_____ **walk with support**_____

**Times child may be fussy:**_____

**How do you handle these fussy times?**_____
**Does your child have any of the following: a physical disability? :**_____ **developmental delay?** _____

**Hearing impairment?** _____ **non verbal ?:** _____ **Alcohol/drug exposure?** _____

**Seizures ?** _____ **cerebral palsy?** _____ **Down syndrome?** _____

**Any other condition not listed?** _____

**Does your child have an Individual Family Service Plan/IEP?** _____
**If so please share information with providers.**

**Does your child need medication daily?**_____**If yes, explain** _____

**Diseases and conditions – Has your child had any of the following?**

**Whooping Cough  Mumps  Measles  Chicken Pox  Asthma  Heart Condition**

**Pneumonia  RSV  Allergies  Eczema  Gastric/Reflux conditions**

**If your child has any of the conditions above please explain the care or prevention for each:**

_____

**INTRODUCING SOLID FOODS:**

**We recommend introducing infant cereal at 4-6 months; vegetables and fruits at 6 months;**

**Protein such as yogurt, cooked beans, meat, fish, chicken, and egg yolks at 6-8 months; whole**

**Eggs at 10-12 months; and milk at 12 months. We can introduce the use of a cup and spoon at 8-10**

**Months. If you do not wish to follow our recommendations, please sign and comment on your preferences:**

_____

**FEEDING:**

**Has your child had any feeding problems? _____If yes explain _____**

**Does your child have a good appetite? _____If no explain_____**

**Does your child have any food allergies? _____If yes complete food allergy form for CACFP**

***Infants only:***

**Is your baby Breast Fed?_____ If so does your child use a bottle for feeding? _____**

**Bottle fed?_____ Name formula_____**

**Special diet/requests:_____**

**Special characteristics or difficulties?_____**

_____

**Child eat:  on lap_____ In high chair_____ Other_____**

**Child eats with: Spoon_____ Fork _____ Hands_____ Other_____**

**Sleeping Information:**

**Does your child sleep in: Crib_____ Bed_____ Family Bed_____**

**In what position does your child prefer to nap:_____**

**What time does child go to bed at night:_____ awake in morning:_____**

**Has your child shown any sleeping problems? _____If yes explain _____**

**What is your child's sleeping routine during the day? A.M._____**

**P.M. _____**

**Do you have any special ways of putting your child to sleep?_____**

**If yes explain _____**

**Does your child usually cry when going to sleep? _____**

**Does child have a favorite blanket or object to help him/her sleep? _____If yes explain_____**

_____

**Social Relationships**

***3-5 yr old only:***

**Is your child: Right handed_____ Left handed _____ Unknown _____**

**# of brothers _____ # of sisters _____**

**Has your child had any experience playing with other children?_____**

**Would you characterize your child as often: Friendly_____ Aggressive____ Shy____ Withdrawn_____**

**Reaction to strangers?_____**

**Favorite toys and activities?_____**

**What is your style of guidance and discipline?_____**

**SEPARATION:**

**Has your child been left in the care of someone other than yourself? Yes____ No_____**

**What difficulty does your child experience separating from you?_____**

_____

**What are some ways to calm your child?_____**

**What are your feelings about leaving your child in our care?_____**

_____

# Parenting Philosophy

**DAILY SCHEDULE:**

**Please describe by approximate time your child's current daily activities (that is, awakening, eating, Time out of crib, napping, toilet habits, fussy time, evening bedtime).**

**MORNING**

_____

_____

**AFTERNOON**

_____

_____

**EVENING**

_____

**As a family what goals do you hope to get out of this childcare experience?**

_____

_____

_____

## Parent Obligation

1. **A parent or guardian shall furnish requested medical information prior to their child's acceptance for enrollment.**

2. **A parent, guardian, or designated representative of the child must sign the child in and out on the appropriate register.**

3. **A parent or guardian shall provide the child with a blanket or other covering to use during naptime.**

4. **The parent or guardian shall see that the child is dressed appropriately when brought to the center.**

5. **The parent or guardian shall provide a written notification to the center when someone other than those named on the application will be taking the child from the center.**

6. **The parent or guardian shall notify the center of the child's possible exposure to communicable disease.**

7. **The parent or guardian shall notify the center by 8:30 A.M. when the child is absent.**

8. **The parent or guardian shall notify the center two weeks in advance when our services are no longer needed.**

9. **The parent or guardian must provide a couple changes of clothes. Infants need diapers provided and bottles marked with child's name. Diaper bags also need to be marked.**

10. **Teen parents must pick up their child by 4:00 PM on Mondays-Thursdays and 2:30 PM on Fridays.**

**BILLING/PAYMENT**

**Your childcare payment will be due on the 15th and 30th of each month.**
**School District 17 H & 1 Teen Parent Program and Child Care Facility reserve the right to refuse service if the payment becomes delinquent. Delinquent is defined as any payment not paid by 5:00 p.m., five business days after the date due.**
**Individuals eligible for Best Beginnings assistance are billed for actual days present at the center.**

**The Center hours of operation are:**
**7:30 a.m. to 4:30 p.m. on Monday, Tuesday, Wednesday and Thursday**
**7:30 a.m. to 4:00 p.m. on Friday**

**The center charges by the day, or the half-day.**
**A deposit equal to one-week of care is required.**
**Example: One infant for a 5 day week would equal a deposit of 5 x 33.00 = 165.00**
**The center follows the School District 17 H & 1 Academic Calendar.**
**If you opt to discontinue childcare services anytime within the academic school year a two-week notice is required.**
**Parents are still responsible for payment of services rendered regardless of quitting date.**

**Parents will be billed for the actual days a child is present at the facility.**

**Infants:**
**Full Day - 33.00 Anytime over 4 hours.**
**Half Day – 16.50**
**Age 2 – 5:**
**Full Day – 27.00 Anytime over 4 hours.**
**Half Day – 13.50**

**Acknowledgement and Agreement to pay for services rendered.**

**Parent Signature:**_____ **Date:**_____

DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

# EMERGENCY CONTACT AND PARENTAL CONSENT

**THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.**

**Child's Name:** _____ **Birth Date:** _____

**Physical Address:** _____

**Mother / Legal Guardian's Name:** _____ **Home Number:** _____

**Address:** _____ **Cell Number:** _____

**Work Address:** _____ **Work Number:** _____

**Father / Legal Guardian's Name:** _____ **Home Number:** _____

**Address:** _____ **Cell Number:** _____

**Work Address:** _____ **Work Number:** _____

**Emergency Contact Person:** _____ **Contact Number:** _____

**Emergency Contact Person:** _____ **Contact Number:** _____

**Physician / Medical Care Source:** _____ **Contact Number:** _____

**Health Insurance Carrier & Policy Number:** _____

**Persons authorized to pick up child:**

**Name:** _____ **Name:** _____

**Name:** _____ **Name:** _____

– SEE REVERSE SIDE –

## WRITTEN CONSENT IS GIVEN FOR:

☐ Yes ☐ No EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS **Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS **OTC Medication Authorization Form and Medication Administration Log must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

☐ TRIPS: ☐ Yes ☐ No TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ Yes ☐ No DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

## HEALTH HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Hay fever, asthma, or wheezing | ☐ | ☐ | Chickenpox | ☐ | ☐ |
| Eczema or frequent skin rashes | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Convulsions/Seizures | ☐ | ☐ | Trouble with passing urine / bowel movement | ☐ | ☐ |
| Heart condition | ☐ | ☐ | Frequent colds, sore throats, earaches, tonsillitis, pneumonia | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| **Allergies or reaction: (food or other)** | ☐ | ☐ |

Please Explain:

| | YES | NO |
|---|---|---|
| **Other Health Concerns (special disabilities):** | ☐ | ☐ |

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN DATE

# STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

**Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.**

## SECTION I

***PLEASE PRINT CLEARLY***

| Child/Student's Name | Birth Date | Sex | Primary Provider | |
|---|---|---|---|---|
| Name of Parent/Guardian | Address | | City | Telephone<br>Home<br><br>Work |

## SECTION II

## IMMUNIZATION HISTORY

**Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).**

| Required Vaccines (CC= Child Care Requirement; SR=School Requirement) | Month, Day & Year of Each Dose 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Diphtheria/Tetanus/Pertussis (DTaP) | CC/SR | CC/SR | CC/SR | CC/SR | SR |
| Booster Dose Td (Tdap recommended) (if given after 10th birth date) | SR | | | | |
| Haemophilus Influenzae Type B (Hib) (Only children less than 5 years) | CC | CC | CC | CC | |
| Measles/Mumps/Rubella (MMR) or | CC/SR | SR | | | |
| Measles vaccine only | | | | | |
| Mumps vaccine only | | | | | |
| Rubella vaccine only | | | | | |
| Polio (IPV or OPV) | CC/SR | CC/SR | CC/SR | SR | |
| Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has documentation of disease | CC | 2nd Dose Recommended | | | |

| ACIP* Recommended Vaccines *Advisory Committee on Immunization Practices; U.S. Centers for Disease Control and Prevention | Month, Day & Year of Each Dose 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| Human Papillomavirus (HPV) - for adolescents | | | | | |
| Influenza- recommended annually for all over 6 mos. | | | | | |
| Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later) | | | | | |
| Pneumococcal Conjugate vaccine (PCV) | | | | | |
| Rotavirus | | | | | |

**NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION**

**If filled out by health department or health care provider:**

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

Signed: _____
*(Health Department/Health Care Provider) Date*

**If filled out by school or child care personnel:**

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
*(School or Child Care Official and title)* *Date*

Signed: _____
*(School or Child Care Official and title)* *Date*

Signed: _____
*(School or Child Care Official and Title)* *Date*

Signed: _____
*(School or Child Care Official and Title)* *Date*

DPH-HS-QAD/CCL-120
(Revision 06-07)

# NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

**TO BE COMPLETED BY PARENT**

Child's Name _____ Date of Birth ____/____/____

Program Name _____ Today's Date ____/____/____

**********

**I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):**

- ☐ Diaper Rash Cream/Ointments
- ☐ Insect Repellent
- ☐ Sunscreen
- ☐ Cortisone/Anti-Itch Creams/Ointments
- ☐ Medicated Lip Treatments
- ☐ OTC Antibiotic Creams/Ointments
- ☐ Burn Creams/Sprays
- ☐ Other Non-Ingestible OTC's: (Please Specify) _____
  - ☐ _____
  - ☐ _____
  - ☐ _____

**To administer a non-ingestible over the counter (OTC) medication:**

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions _____ Refrigeration Y/N

**Parent/Guardian Signature** (required) _____

* **This document must be updated on an annual basis.**

**Unused Medication:** Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date ____/____/____

***Keep in the child's file when medication is finished.**