



REGISTRATION FORM

Enrolling for Child Care

- Full time
- Part-time (must share spot) Days attending: M T W TH F

Child

Sex: M F Date of Birth: _____
Name: _____
Preferred Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: () _____
Center Admittance Date: _____

First Parent or Guardian

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: () _____
Cell Number: () _____
Company/Employer Name: _____
Address: _____
Work Number: _____ Extension: _____
Work Hours: _____

Second Parent or Guardian

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: () _____
Cell Number: () _____
Company/Employer Name: _____
Address: _____
Work Number: _____ Extension: _____
Work Hours: _____



Emergency/Illness

(This should be someone other than parents or legal guardians who could pick up your child within ½ hour after being notified. We will use these contacts only if we are unable to locate the parent or guardian first.)

Name: _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: () _____ Cell Number: () _____

Name: _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: () _____ Cell Number: () _____

Pick Up

(This is anyone other than parents or legal guardians who may pick up your child.)

Name: _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: () _____ Cell Number: () _____

Name: _____

Relationship to Child: _____

Address: _____

City:State:Zip Code: _____

Daytime Phone Number: () _____ Cell Number: () _____

Unauthorized Pick Up

(This is anyone who **MAY NOT** pick up your child.

Must have legal documentation in relationship situations.)

Name: _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: () _____ Cell Number: () _____

Medical Information

Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: () _____

Allergies: _____

Medical Conditions: _____

Any seizures? _____

Any problems with blood sugars? _____

Preferred Hospital: _____

Other Information: _____

Are there any other persons living in the household? _____

Have there been any major life changes for your child recently? _____

Move: _____

Seperation: _____

Divorce: _____

New baby: _____

Hospitalization (whom): _____

Death: _____

Other: _____

IMMUNIZATION RECORD

Name of Child: _____

Vaccine	Vaccine Type	Dose	Normal Schedule	Date Given			Doctor or Clinic Administering
				Month	Day	Year	
Polio OPV or IPV		1	2 mo				
		2	4 mo				
		3	6-18 mo				
		4	4-6 yrs				
DTaP Diphtheria Tetanus Pertussis		1	2 mo				
		2	4 mo				
		3	6 mo				
		4	15-18 mo				
		5	4-6 yrs				
MMR MMR Measles Rubella Mumps		1	12-15 mo				
		2	4-6 yrs				
		1					
		1					
Hepatitis B		1	Birth-2mo				
		2	1 month after 1st				
		3	5 mo after 2nd				
Hib Haemophilus Influenza B		1	2 mo				
		2	4 m				
		3	6 mo				
		4	12-15 mo				
Pneumo		1	2 mo				
		2	4 mo				
		3	6 mo				
		4	12-15 mo				
Varicella		1	12-18 mo				
Hepatitis A Recommended in selected areas for chil- dren over 2 yrs		1	Over 2 yrs At least 6 mo after 1st				

*This chart is based on the Immunization schedule recommended by the CDC, American Academy of Pediatrics, and the Academy of Family Physicians. (www.cdc.gov)



PERMISSION TO PARTICIPATE IN ACTIVITIES AND TO RECEIVE EMERGENCY MEDICAL CARE

I hereby grant permission for:

- my child to use all of the play equipment and participate in all of the activities of the CDC. This may include water activities.
- my child to leave the school premises under the supervision of CDC staff members for walks or field trips in an authorized vehicle. I will be informed of any off-campus events in advance.
- my child to be included in center assessments or research conducted at the CDC. I will be informed of any such assessment or research in advance.
- my child to participate in photographing, audio/video taping that may take place in the CDC programs or by Capitol City Christian Church.
- my child's photo to be used publicly for educational and/or promotional purposes for the CDC or Capitol City Christian Church.
- my child to be included in any newspaper, radio, or television coverage the program or Capitol City Christian Church may receive.
- the CDC staff to take whatever steps may be necessary to obtain emergency medical care for my child, if warranted. These steps may include, but are not limited to, the following:
 1. The school will attempt to contact a parent or guardian prior to taking the child for medical treatment or care.
 2. In case of a serious accident, the CDC will call 911.
 3. Any expenses incurred under #2 above will be borne by the child's family.
 4. The CDC will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
 5. The CDC will not assume responsibility for a child who has not been signed in when he/she arrives for the day. **Parents must accompany a child to his or her room and report to the teacher.**

Name of Child: _____ Date: _____

Parent/Guardian's Signature: _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____



ILLNESS POLICY

If your child will be staying home because he or she is sick, please call the CDC (467-4503), as soon as possible to let the staff know that he or she will not be coming.

Children should not attend the CDC for the following reasons:

- Any infectious disease
- A fever of 100 degrees or higher. (The child will not be allowed to return to the center for 24 hours after the fever returns to normal without the use of medications, such as Tylenol. For example, if a child is given medicine at 10:00 am, then the 24 hour period would begin at 2:00 pm.)
- Until 24 hours after antibiotics are started
- A deep chest or croup-like cough
- An undiagnosed rash
- An inability to cope with group situations because of illness
- Vomiting
- Two diarrhea stools which cannot be contained in diapers or pants (including stools at home)
- Oozing sores
- Head lice (may not return until child is free from all nits)
- Pink eye or other discharge from eyes
- Misery with cold, including discharge from eyes and other symptoms

Please Note: Tylenol (or similar medicine) may not be administered at the CDC with the onset of an unknown illness. This may mask initial symptoms of a potentially contagious illness.

Your child must be picked up **within ½ hour** after you are notified. This will help us to provide a healthier environment for all of our children.

If there needs to be a deviation from the above guidelines, we do request a written note from your health care professional.*

*There may be times when we will not accept a note based on the State Health Department's recommendations or due to varying opinions among health care professionals.

Your child's health and safety is of utmost importance to us at Fingerprints. We try to be very careful when determining whether or not a child should be at the CDC. We realize this can be a difficult decision for teachers and parents. It is difficult because a child may feel much better when resting at home as opposed to having to keep up with other children at the CDC. We are open to visiting with you about any questions you may have regarding a decision that was



ADMINISTRATION OF MEDICATION

In keeping with the standards set by Health and Human Services Regulation and Licensure, **Fingerprints Child Development Center's** administration of medication procedure is as follows:

- All medications (prescribed and over-the-counter) will be kept in a centralized location. They will be kept in a locked cabinet in the Nursery. All medications that require refrigeration will be kept in a locked container in the refrigerator in the Nursery. No medications will be kept in individual classrooms.
- Any request for medication to be given or for medication to be applied must be accompanied by a signed Medication Permission sheet (short-term or long-term), including written instructions. These can be found in your child's classroom. A Medication Permission sheet must be completed by the parent and/or guardian each day that medication is to be given.
- If a parent indicates that dosage for an over-the-counter medication should exceed that which is printed on the label, a written set of instructions must be provided by the prescribing healthcare professional on their letterhead or prescription pad. (For example, if the label calls for ½ of a Tylenol tablet, a written note must be present if a whole tablet is to be administered.)
- Medications should be taken home daily and will be sent home each Friday.
- Expired medicines or those which do not bear the child's name will not be given and will be thrown away.
- All medications must remain in their original containers with the child's prescription from the doctor on them. We cannot accept medicine in Baggies or that is hand-labeled.
- Medication may be administered by the director or other designated staff.

These guidelines follow the standards that the state requires. We feel they are in the best interest of the children and allow us to better monitor their health. Thank you for your cooperation!

I have read the preceding guidelines and agree to follow them in determining when to keep my child at home. I also agree to pick up my child when he or she becomes ill at Fingerprints CDC within ½ hour after I am contacted.

Child's Name: _____ Date: _____

Parent or Guardian's Signature: _____

Parent or Guardian's Signature: _____



COMPETENCY STATEMENT

I, _____ have determined Fingerprints Child Development Center staff competent to give or apply medication to my child(ren).

Signature of Parent/Guardian

Date

Child and Adult Care Food Program (CACFP) - Nebraska Department of Education Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Attach additional pages if necessary. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

PLEASE PRINT LEGIBLY

Check if Head Start Eligible

Indicate the expected attendance patterns of each child enrolled:

Child 1: Last Name	First Name	Date of Birth	Date Enrolled
Days in Care	Usual Hours in Care	Usual Meals to be Received While in Care	
<input type="checkbox"/> Monday	to	<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack
<input type="checkbox"/> Tuesday	to		
<input type="checkbox"/> Wednesday	to		
<input type="checkbox"/> Thursday	to		
<input type="checkbox"/> Friday	to		
<input type="checkbox"/> Saturday	to		
<input type="checkbox"/> Sunday	to		
<input type="checkbox"/> Non-school days/holidays	to		

Child 2: Last Name	First Name	Date of Birth	Date Enrolled
Days in Care	Usual Hours in Care	Usual Meals to be Received While in Care	
<input type="checkbox"/> Monday	to	<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack
<input type="checkbox"/> Tuesday	to		
<input type="checkbox"/> Wednesday	to		
<input type="checkbox"/> Thursday	to		
<input type="checkbox"/> Friday	to		
<input type="checkbox"/> Saturday	to		
<input type="checkbox"/> Sunday	to		
<input type="checkbox"/> Non-school days/holidays	to		

Child 3: Last Name	First Name	Date of Birth	Date Enrolled
Days in Care	Usual Hours in Care	Usual Meals to be Received While in Care	
<input type="checkbox"/> Monday	to	<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch	<input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack
<input type="checkbox"/> Tuesday	to		
<input type="checkbox"/> Wednesday	to		
<input type="checkbox"/> Thursday	to		
<input type="checkbox"/> Friday	to		
<input type="checkbox"/> Saturday	to		
<input type="checkbox"/> Sunday	to		
<input type="checkbox"/> Non-school days/holidays	to		

Date signed:

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Month Day Year

This CACFP enrollment form is valid for one year from the date the parent or guardian signs the form.

Annual Update - parent may sign & date if the above information is still current.

Signature of Parent or Legal Guardian

Printed Name

Street Address

City, State, Zip

Telephone (include area code)

APPLICATION FOR FREE AND REDUCED PRICE MEALS IN THE CHILD AND ADULT CARE FOOD PROGRAM

Part 1. Enrolled children's information Attach an additional page if necessary. Complete a separate application for each foster child.			Part 2. Benefit Information If applicable, circle type of benefit. Case number required
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y	Food Stamp, TANF or FDPIR (if any)
			Case Number:
			Case Number:
			Case Number:
			Case Number:

Part 3. Foster/Institutionalized Child

Check this box if this application is for a foster child or a child who is residing in an institution. List the amount of the child's personal use monthly income: \$_____. If there is no income, record "0". Go to Part 5.

Part 4. Total Household Income from Last Month – Complete Part 4 for any child without a case number

Names of all household members not listed in Part 1	HOUSEHOLD INCOME				Check if NO income
	List last month's income below. Do not list hourly wage.				
Last Name, First Name	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>
	\$	\$	\$	\$	<input type="checkbox"/>

Part 5. Signature and Social Security Number

The adult household member who fills out the application must sign below. If Part 5 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page). If you have given a case number in Part 2 or if this application is for a foster child, a social security number is not needed.

I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print Name _____

Social Security Number: _____ Street Address _____

I do not have a Social Security Number City/State/Zip _____

Date Signed _____ Telephone _____

Part 6: (Optional) Racial/Ethnic Identity of children listed in Part 1

Mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

Mark one or more racial identities: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other

FOR CENTER USE ONLY

<p>Zero Income</p> <p>Temporary Free Approval Until:</p> <p>_____</p> <p>Must be reviewed in 45 days</p>	Totals from Part 5, if applicable:	<input type="checkbox"/> Free <input type="checkbox"/> Food Stamps/TANF/FDPIR
	Total Household Size _____	<input type="checkbox"/> Foster Child
Total Monthly Income \$ _____	<input type="checkbox"/> Household Size & Income	<input type="checkbox"/> Reduced
	<input type="checkbox"/> Paid Reason for Denial:	<input type="checkbox"/> Income Too High
		<input type="checkbox"/> Incomplete

Signature of Center Official

Today's Date

Effective Date
(no earlier than first of current month)

Privacy Act Statement: This explains how we will use the information you give us.

The National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your children for free or reduced price meals. The Social Security Number of the adult household member who signs the application is required unless you list Food Stamp, FDPIR or TANF case numbers for all children you are applying for, OR if you are applying for a foster child. You must check the "I do not have a Social Security Number" box if the adult household member signing the application does not have a Social Security Number. We WILL use your information to see if your children are eligible for free or reduced price meals, to run the program, and to enforce the rules of the program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into misuse of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

For assistance completing this form, contact the center:

Center Name _____

Address _____

City, State, Zip _____

Contact Person _____

Telephone _____

The State Agency administering the Child and Adult Care Food Program is:

Nebraska Department of Education
Nutrition Services
P.O. Box 94987
Lincoln, NE 68509

Telephone: (402) 471-2488

Web site: <http://www.nde.state.ne.us/NS>