Otterbein United Methodist Church
647 Forge Road, Carlisle, PA 17015 ~ (717) 258-6704
Bright Beginnings Child Care of Carlisle ~ (717) 258-8216 ext.103

Enrollment Forms

- Emergency Contact / Parental Consent
- Child Health Report
- Automatic Tuition Payment Agreement
- Getting To Know You Meeting (School Age)
- Hand Lotion, Chap-stick and Sunscreen Permission
- Photo Release for Children / Publication Permission Form
- Infant/Toddler (Birth to 36 Months) Development & Routine
- Preschool (3-5 Years Old) Development & Routine

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290. 124 (a)(b), 3290. 181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN — DATE

SIGNATURE OF PARENT or GUARDIAN — DATE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

Screening	
VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Automatic Tuition Payment Agreement

We invite you to enroll in our Automatic Tuition Payment program. It's easy, convenient and efficient. This program deducts your tuition automatically from your checking or savings account each week. Your Automatic Tuition Payment transactions can be deducted from accounts at virtually any financial institution (bank, credit union, etc.). These transactions will appear each month on your bank statement.

To take advantage of the Automatic Tuition Payment program, simply complete the agreement below and return it to the church office.

Automatic Tuition Payment Agreement

Name ____

Address ____

Child's Name(s) ____

Phone Number(s)____

Email:____

I hereby authorize **Otterbein United Methodist Church, Carlisle, PA** to initiate debit entries to my account indicated below, and the financial institution named below to process those entries. Each such debit shall be made weekly based on my authorized amount and tuition schedule. This authority shall remain in effect until I notify you in writing.

Financial Institution ____

Bank ABA (routing) Number ____

Account Number ____

(Please attach a voided check to this form to verify bank routing number and account number)

Please indicate if this is a checking or savings account (circle one)

Signature ______________________________ Date______________________________

(owner of payment account)

***Total Weekly Amount*:** $__________

You will receive a one-time per year discount of $10 on the annual registration fee during the month of the anniversary of enrollment.

Dec. 2013

Getting To Know You Meeting (School-Age)

Child's Name:
Parent's Names:
Date of Enrollment:
Date of Meeting:

Meeting Notes:

Does your child go by any nicknames?
Do they have nicknames for family members?

Does your child have parents that do not live in the home?
If so, what are the custody arrangements?

Does your child have siblings? Names and ages?

Has your child been in day care before?
If so, is there a reason for leaving that you would like to share with me?

Do you have your child's records from that place?

Does your child have any special needs?

Does your child have allergies?

If so, what are they and how are they treated?

Is there anything that we can do to make your child's first few days easier?

Is there any other information that you would like to share with me today?

Parent Signature:____Date________________

Does the Parent request a meeting within 45 days to discuss their child's progress? YES NO

Parent Signature:____Date_________________

Hand Lotion and Chap-stick Permission

I give permission for the staff of Bright Beginnings Child Care of Carlisle to apply hand lotion and or chap-stick to my child as necessary. I understand that I will provide all lotion and chap-stick for my child's own individual use. I will label all items sent with my child.

Child's Name:____

Parent Signature:____

Date:____

Sunscreen Permission

I give my permission for the staff of Bright Beginnings Child Care of Carlisle to apply the sunscreen lotion which I have provided for my child on the days when the weather warrants sunscreen protection. I understand that the sunscreen will be in the original, unbreakable container and labeled with my child's name.

Child's Name____

Parent's
Signature____Date:________________

Photo Release for Children

I hereby grant permission to Bright Beginnings Child Care of Carlisle and to its employees the right to photograph my dependent and use the photo or digital production of him/her for the postings within the Center as well as for slide shows that may be played during family events.

Child's Name:____

Print Name of Parent/Guardian:____

Signature of Parent/Guardian:____

Date:___________________________________

Publication Permission Form

To further the purpose, objective, and work of Bright Beginnings Child Care of Carlisle, the undersigned grant permission to Bright Beginnings Child Care of Carlisle's employees to take pictures and use video of me/us/him/her and to use our names in conjunction with any news release or story. Further, I/we/grant my/our permission for Bright Beginnings Child Care of Carlisle to use and distribute for publication any such photographs, video, news release, or stories for any purpose(s) it may deem proper, including, but not limited to publicity and educational purposes.

Child's Name:____

Print Name of Parent/Guardian:____

Signature of Parent/Guardian:____

Date:____________________________________

INFANT/ TODDLER (Birth to 36 Months)
DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name: ______________________________

Daily Routines

Sleeping

1.) Please describe your child's usual bedtime routine (including time and where he/she usually sleeps). ______________________________
____

2.) How do you know your child is sleepy/ tired? ______________________________

3.)Does your child have any difficulties falling asleep? ______ If yes, what is helpful?
____

4.) About how many hours of uninterrupted sleep does your child get each night? ________

5.) How many times per day does your child nap? _____ How many hours on average?

6.) Does your child sleep with a special blanket, toy, pacifier, song?
____

7.) Do you have any concerns about your child's sleep habits? ______ If yes, please explain. ______________________________

Eating

1.) Does your child generally enjoy eating? ______________ Do *you* consider your child a good eater? __________

2.) What are some of your child's favorite foods? ______________________________
____

3.) Is your child on any special diet? ______________________________

4.) If your child has any food allergies, please list here: ______________________________

5.) Do you breastfeed your child? ________ If so, how often? ______________

6.) What does your child eat with? (hands, spoon, fork) ______________________________

7.) Does your child eat independently? ________________

8.) What does your child use to drink? (bottle, sippy cup, cup) ______________________

9.) Do you have any questions about your child's eating habits? ______________________

If yes, please explain ______________________________

Toileting

1.) Does your child wear diapers? ________

If yes what kind? __disposable ___cloth _____pull- ups For naps? ____________

2.) If no, does your child use the toilet regularly?______________________________

3.) Indicate the words your family uses for the following:

Urine_______________ Bowel Movement__________ Genital area__________

4.) Do you have any concerns about your child's toileting habits? ______________________

If yes, please explain ______________________________

Play

1.) Does your child have a favorite toy/ object or song? ______________________________

2.) Does your child enjoy playing with others?____________ Alone? ____________

3.) What activities does your child enjoy? ______________________________

TURN OVER PLEASE

Health

1.) Does your child have any health problems?_______ If yes, please explain: ______

____

2.) Is your child taking any medications regularly? _______ If yes, please explain: _________

____

3.) Does your child have a chronic health condition or specific health needs? ___________

____

____

4.) Does your child have frequent ear infections? ________ diarrhea? ___________

5.) Do you have any concerns about your child's health? ____________________

** Children in group care may become ill with colds, viruses, etc. several times per year. At times we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please review our handbook for further details.*

General Development

Do you have any concerns about your child's:

Hearing and/ or vision? ____

Speech and language development? ______________________________

Ability to move? ____

Overall development? ____

Does your child receive developmental services (LIU, Early Intervention)? __________

What languages are spoken at home? ______________________________

What is your family's cultural identification (values, traditions)? ________________

____

What school district will your child attend? ______________________________

Social and Emotional Development

Has your child been in group care? ________ If yes, how many different settings? _______

How does your child respond in group situations? ________________________

What can we do to help your child adjust to child care? ____________________

____

How would you describe your child's temperament? _______________________

How does your child communicate his needs? ____________________________

How do you comfort your child? _______________________________________

Does your child use a special comforting item? __________________________

Does your child fear certain things? ___________________________________

How is your child disciplined? ____

What works best when you discipline your child? ________________________

Do you have any concerns about your child's social- emotional development or behavior?

____

What educational/ developmental experiences would you like us to emphasize with your child(ex. Language development, social relationships, kindergarten readiness, self help skills, etc.)?

____

*** PLEASE PROVIDE US WITH A WRITTEN SCHEDULE FOR YOUR *INFANT****

Parent's Signature________________________________ Date______________

Does Parent request a meeting with in 45 days to discuss their child's progress? **YES** **NO**

Parent Signature:____________________________________Date:______________

PRESCHOOL (3- 5 Years Old)
DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name: ______________________________

Daily Routines

Sleeping

1.) Please describe your child's usual bedtime routine (including time and where he/she usually sleeps). ______________________________
____

2.) How do you know your child is sleepy/ tired? ______________________________

3.)Does your child have any difficulties falling asleep? ______ If yes, what is helpful?
____

4.) About how many hours of uninterrupted sleep does your child get each night? ________

5.) How many times per day does your child nap? _____ How many hours on average?

6.) Does your child sleep with a special blanket, toy, pacifier, song?
____

7.) Do you have any concerns about your child's sleep habits? ______ If yes, please explain. ______________________________

Eating

1.) Does your child generally enjoy eating? ____________ Do *you* consider your child a good eater? __________

2.) What are some of your child's favorite foods? ______________________________
____

3.) Is your child on any special diet? ______________________________

4.) If your child has any food allergies, please list here: ______________________________

5.) What does your child eat with? (hands, spoon, fork) ______________________________

6.) Does your child eat independently? ________________

7.) What does your child use to drink? (sippy cup, cup) ______________________

8.) Do you have any questions about your child's eating habits? ____________________
If yes, please explain ______________________________

Toileting

1.) What does your child usually wear during the day? __underwear ___diaper _____pull-ups For naps? ____________

2.) Indicate the words your family uses for the following:
Urine______________ Bowel Movement__________ Genital area__________

3.) Do you have any concerns about your child's toileting habits? ____________________
If yes, please explain ______________________________

Play

1.) What is your child's favorite toy/ object or song? ______________________________

2.) Does your child enjoy playing with others?___________ Alone? ____________

3.) What activities does your child enjoy? ______________________________

TURN OVER PLEASE

Health

1.) Does your child have any health problems?_______ If yes, please explain: ______

____

2.) Is your child taking any medications regularly? _______ If yes, please explain: _________

____

3.) Does your child have a chronic health condition or specific health needs? ___________

____

____

4.) Does your child have frequent ear infections? ________ diarrhea? ___________

5.) Do you have any concerns about your child's health? ______________________

** Children in group care may become ill with colds, viruses, etc. several times per year. At times we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please review our handbook for further details.*

General Development

Do you have any concerns about your child's:

- Hearing and/ or vision? ______________________________
- Speech and language development? ____________________
- Ability to move? ___________________________________
- Overall development? ______________________________

Does your child receive developmental services (LIU, Early Intervention)? ___________

What languages are spoken at home? ___________________________

What is your family's cultural identification (values, traditions)? ______________

____

What school district will your child attend? _________________________

Social and Emotional Development

Has your child been in group care? ________ If yes, how many different settings? _______

How does your child respond in group situations? ______________________

What can we do to help your child adjust to child care? ___________________

____

How would you describe your child's temperament? ______________________

How does your child communicate his needs? __________________________

How do you comfort your child? ________________________________

Does your child use a special comforting item? _________________________

Does your child fear certain things? ____________________________

How is your child disciplined? _________________________________

What works best when you discipline your child? ________________________

Do you have any concerns about your child's social- emotional development or behavior?

____

What educational/ developmental experiences would you like us to emphasize with your child(ex. Language development, social relationships, kindergarten readiness, self help skills, etc.)? _________________________________

____

Parent's Signature_______________________________ Date____________

Does Parent request a meeting with in 45 days to discuss their child's progress? **YES** **NO**

Parent Signature:_______________________________Date:____________