ALL CHILDREN OF THE WORLD - REGISTRATION FORM

ORIGINAL ENROLLMENT DATE: _____

DATE UPDATED: _____

CHILD'S NAME _____ BIRTHDATE:_____

First^ Middle^ Last^

NAME CHILD GOES BY _____

PARENT INFORMATION (CONTACT FIRST)

NAME _____

HOME ADDRESS & ZIP:

_____

HM # _____ CELL #_____

DO YOU ACCEPT TXT'S? YES / NO

WORK/ALTERNATE #_____

(OR WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE)

WORK PLACE _____

(OR WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE)

EMAIL:

PARENT INFORMATION (CONTACT SECOND)

NAME _____

HOME ADDRESS & ZIP:

_____

HM # _____ CELL #_____

DO YOU ACCEPT TXT'S? YES / NO

WORK/ALTERNATE #_____

(WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE)

WORK PLACE_____

(OR WHERE YOU CAN BE REACHED WHILE CHILD IS IN CARE)

EMAIL:

OTHER THAN PERSONS ABOVE, LIST PERSONS TO NOTIFY IN CASE OF EMERGENCY:

NAME _____

CONTACT INFORMATION WHILE CHILD IS IN CARE:

_____

_____ PERMISSION TO PICK UP IN AN EMERGENCY IF YOU CANNOT BE REACHED?. YES / NO

RELATIONSHIP TO CHILD:

NAME _____

CONTACT INFORMATION WHILE CHILD IS IN CARE:

_____

_____ PERMISSION TO PICK UP IN AN EMERGENCY IF YOU CANNOT BE REACHED? YES / NO

RELATIONSHIP TO CHILD:

CHILD'S PHYSICIAN NAME & CONTACT INFO: _____

DATE OF LAST PHYSICIAN VISIT: _____

CHILD'S DENTIST NAME & CONTACT INFO: _____

DATE OF LAST DENTIST VISIT: _____

OTHER THAN PARENTS, WHO ELSE HAS PERMISSION TO PICK UP YOUR CHILD? (IF NONE WRITE 'NONE")

NAME RELATIONSHIP TO CHILD

_____ _____ CONTACT PH#_____

_____ _____ CONTACT PH#_____

_____ _____ CONTACT PH#_____

WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD? (IF NONE WRITE 'NONE")

(A COPY OF SUPPORTING COURT DOCUMENTS MUST TO BE ON FILE IF PERTAINING TO CUSTODIAL PARENT - DOCUMENTS WILL BE KEPT CONFIDENTIAL)

NAME _____ **REASON** _____

NAME _____ **REASON** _____

INFORMATION & PERMISSION FORM FOR _____

^INSERT CHILD'S NAME

~ ANY ON GOING HEALTH AND OR DEVELOPMENTAL ISSUES I SHOULD BE AWARE OF? YES / NO

IF YES, PLEASE EXPLAIN: _____

_____

YES / NO DOES YOUR CHILD HAVE ANY DIAGNOSED SPECIAL NEEDS THAT WILL NEED AN INDIVIDUAL CARE PLAN?

(I.E. INDIVIDUAL EDUCATION PLAN (IEP); INDIVIDUAL HEALTH PLAN (IHP); 504 PLAN OR INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

~ WOULD YOUR CHILD NEED TO TAKE MEDICATION(S) ON A REGULAR BASIS WHILE IN CARE? YES / NO

IF YES, PLEASE LIST MEDICATIONS: _____

(IF YOUR CHILD TAKES MEDICATION AT HOME THAT IS VITAL TO THEIR HEALTH, I NEED A THREE (3) DAY SUPPLY IN MY PROCESSION IN CASE OF AN EMERGENCY SITUATION - SEE DISASTER PREPAREDNESS SECTION OF THE PARENT HANDBOOK)

~ DOES YOUR CHILD HAVE ANY BEHAVIORAL CHALLENGES THAT WILL NEED TO BE TAKEN INTO CONSIDERATION? YES / NO

IF YES, PLEASE EXPLAIN: _____

_____

~ DOES YOUR CHILD HAVE ANY FOOD OR OTHER ALLERGIES WE NEED TO BE AWARE OF? YES / NO

IF YES, PLEASE SPECIFY FOOD OR OTHER ALLERGY & WHAT TYPE OF REACTION THE CHILD HAS AND REQUEST AN INDIVIDUAL CARE PLAN FORM.

_____

_____

~ IS THERE ANY INFORMATION YOU WISH TO SHARE IN REGARDS TO YOUR FAMILY'S LINGUISTICS, CULTURE, ETHNICITY AND/OR BELIEFS? YES / NO _____

_____

YES / NO HAS YOUR CHILD EVER HAD PEANUT BUTTER? (PEANUT BUTTER MUST FIRST BE INTRODUCED TO THE CHILD BY THE PARENT WITHOUT ALLERGIC REACTION BEFORE CHILD IS OFFERED PEANUT BUTTER BY THE PROVIDER)

YES / NO DO I (DEBORAH THURBER OR ONE OF HER PRIMARY STAFF PERSONS) HAVE YOUR PERMISSION TO TAKE YOUR CHILD ON OCCASIONAL WALKS AROUND THE NEIGHBORHOOD?

YES / NO DO I (DEBORAH THURBER OR ONE OF HER PRIMARY STAFF PERSONS) HAVE YOUR PERMISSION TO TAKE MORALLY APPROPRIATE PICTURES OF YOUR CHILD FOR THE SOLE PURPOSE OF SHARING WITH YOU, THEIR PARENTS VIA TEXT?

YES / NO DISPLAYING ON THE ALL CHILDREN OF THE WORLD'S FACEBOOK PAGE WITH FACES SKEWED AND NOT TAGGED?

FOR SAFETY REASONS, YOU AND YOUR CHILD'S IMAGE MAY BE CAPTURED ON OUR RING® SURVEILLANCE SYSTEM

YES / NO DO WE HAVE YOUR PERMISSION TO SERVE YOUR CHILD FOOD PREPARED, COOKED, OR BAKED BY ANOTHER CHILD'S PARENT, ON SPECIAL EVENTS LIKE BIRTHDAYS AND/OR HOLIDAYS?
**** WE WILL ALWAYS TAKE INDIVIDUAL ALLERGIES INTO CONSIDERATION. ****

YES / NO DO I HAVE YOUR PERMISSION TO BATHE OR SHOWER YOUR CHILD IF THE NEED ARISES SUCH AS VOMITING OR DIARRHEA? (PRIOR NOTIFICATION WILL BE GIVEN)

YES / NO DOES YOUR CHILD HAVE PERMISSION TO PARTICIPATE IN SUPERVISED WATER ACTIVITIES PLANNED BY STAFF WHILE IN OUR CARE?

I WISH TO OPT MY CHILD OUT OF THE DAILY TOOTH BRUSHING REQUIREMENT ⇨ _____

^ PARENT OR GUARDIAN SIGNATURE ^

OR

YES I GIVE PERMISSION FOR DEBORAH THURBER OR ONE OF HER QUALIFIED ASSISTANTS TO ASSIST MY CHILD IN DAILY TOOTH BRUSHING ACTIVITIES - I, THE PARENT OR GUARDIAN, UNDERSTAND THAT I WILL NEED TO SUPPLY NON-FLUORIDE TOOTHPASTE AND AN AGE-APPROPRIATE SIZED TOOTHBRUSH AND AGREE TO REPLACE TOOTHBRUSH EVERY THREE (3) MONTHS OR WHEN DEEMED NECESSARY. INITIALS: ⇨ _____

*****I/WE HAVE READ, REVIEWED, AND UNDERSTAND ALL CHILDREN OF THE WORLD'S PARENT HANDBOOK AND EARLY LEARNING PROGRAM POLICIES. FAILURE TO COMPLY WITH ALL CHILDREN OF THE WORLD'S HANDBOOK PROCEDURES COULD RESULT IN TERMINATION OF CHILD CARE.**

⇨ _____ ⇨ _____ _____

^ PARENT(S) OR GUARDIAN SIGNATURES ^ DATE

PAYMENT AND TIME AGREEMENT WITH ALL CHILDREN OF THE WORLD

DAY'S AND TIMES PER WEEK FOR ENROLLMENT:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
~	~	~	~	~

I am a slot-based program and the fee below are charges for the time listed above and cannot exceed my scheduled hours or more than 10 hours/day. Any scheduled days requiring more than 10 hours of care is subjected to additional fees

I (THE PARENT/GUARDIAN) AGREE TO BE ON TIME.
I (THE PARENT/GUARDIAN) ALSO AGREE TO PAY A $1.00 PER MINUTE LATE FEE IF MY CHILD(REN) ARE NOT PICKED UP WITHIN 10 MINUTES OF THE SCHEDULED PICK UP TIME AND A CALL/TEXT HAS NOT BEEN MADE TO THE PROVIDER, **OR** IF I (THE PARENT/GUARDIAN) AM LATER THAN 5:30 PM REGARDLESS….STRICTLY ENFORCED….
INITIALS: _____ _____

IF YOU ARE UNAVOIDABLY DETAINED, I ASK THAT YOU PHONE/TEXT ME.

I (THE PARENT/GUARDIAN) AGREE TO THE DAILY RATE OF: $ _____ FOR:_____
$ _____ FOR _____ $ _____ FOR:_____
THIS FEE IS FOR THE TIMES AGREED UPON AND WRITTEN IN AT THE TOP OF THIS PAGE ONLY.
ANY ADDITIONAL CARE TIME NEEDED IS SUBJECTED TO EXTRA FEES AND WILL BE DISCUSSED IF THE NEED ARISES.
EXAMPLE: EARLY MORNING CARE (BEFORE 6:30 AM); EVENING CARE (AFTER 5:30PM) AND/OR WEEKEND CARE.
PROVIDER (DEBORAH THURBER) MAY TERMINATE THIS AGREEMENT AT WILL

I (THE PARENT/GUARDIAN) AGREE TO MAKE REGULAR PAYMENTS IN THE AMOUNT OF $_____
(CIRCLE PREFERENCE)

DAILY **WEEKLY** **BI-WEEKLY** **2X MONTH** **MONTHLY** **OTHER:**_____

DUE DATE(S) OR DAY(S): _____

PAYMENT IS MADE IN ADVANCE AND WHETHER OR NOT YOUR CHILD(REN) ARE PRESENT, REGARDLESS OF ILLNESS, HOLIDAY, PROVIDER VACATIONS, OR PERSONAL VACATION. INITIALS: _____ _____

I (THE PARENT/GUARDIAN) UNDERSTAND THAT THERE IS A **5% LATE FEE OF $_____ or $5 WHICHEVER IS LARGEST** FOR ANY PAYMENT NOT MADE BY THE AGREED-UPON DUE DATE OR DAY SPECIFIED ABOVE.
INITIALS: _____ _____

IF I (THE PARENT/GUARDIAN) AM MORE THAN FIVE (5) DAYS LATE, I (THE PARENT/GUARDIAN) KNOW THAT MY CHILD CARE COULD BE DISCONTINUED. INITIALS: _____ _____

I (THE PARENT/GUARDIAN) WILL GIVE AT LEAST A 2 WEEK NOTICE IF I (THE PARENT/GUARDIAN) NEED TO UN-ENROLL MY CHILD(REN) FROM CARE AND UNDERSTAND THAT I WILL BE MONETARILY RESPONSIBLE FOR THOSE TWO WEEKS. INITIALS: _____ _____

I, THE PARENT/GUARDIAN, UNDERSTAND IF UPON LEAVING, THERE IS AN OUTSTANDING BALANCE, A **$5.00/DAY** LATE FEE WILL BE ADDED TO THE UNPAID BALANCE UNTIL PAID IN FULL. INITIALS: _____ _____

****THERE IS A $30.00 CHARGE FOR ANY RETURNED/NSF CHECKS.** (THIS COVERS MY BANK CHARGE)****

I (THE PARENT(S)/GUARDIAN) **UNDERSTAND THE PAYMENT AND TIME AGREEMENT WITH ALL CHILDREN OF THE WORLD AS OUTLINED ABOVE AND I** (THE PARENT(S)/GUARDIAN) **AGREE TO PAY ALL CHARGES INCURRED.**

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____
SIGNATURE OF CHILD CARE PROVIDER DATE

EMERGENCY CONSENT FOR TREATMENT OF MINOR CHILD

I, THE UNDERSIGNED PARENT OR GUARDIAN OF _____, A MINOR, HEREBY GIVES
(^ PRINT CHILDS'S NAME ABOVE^)
PERMISSION TO ADMINISTER FIRST AID/ EMERGENCY TREATMENT (NOT REQUIRING PROFESSIONAL MEDICAL TREATMENT) BY **DEBORAH THURBER OR ONE OF HER QUALIFIED STAFF** WHILE MY CHILD IS IN CARE,

_____ ⇨ _____ _____ ⇨ _____
^^DATE^^ ^^PARENT/GUARDIAN SIGNATURE^^ ^^ DATE ^^ ^^PARENT/GUARDIAN SIGNATURE^^

WHEN I CAN NOT BE CONTACTED, I AUTHORIZE AND CONSENT TO MEDICAL, SURGICAL, AND HOSPITAL CARE, TREATMENT AND HOSPITAL CARE, TREATMENT AND PROCEDURES TO BE PERFORMED FOR MY CHILD BY A LICENSED PHYSICIAN; HEALTH CARE PROVIDER; HOSPITAL OR AMBULANCE ATTENDANT AND BE TRANSPORTED BY AMBULANCE TO AN EMERGENCY CENTER WHEN DEEMED NECESSARY OR ADVISABLE BY THE PHYSICIAN OR AMBULANCE ATTENDANT TO SAFEGUARD MY CHILD'S HEALTH. I WAIVE MY RIGHT OF INFORMED CONSENT TO SUCH TREATMENT.
I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THIS INFORMATION IS TRUE AND CORRECT.

_____ ⇨ _____ _____ ⇨ _____
^^DATE^^ ^^PARENT/GUARDIAN SIGNATURE^^ ^^ DATE ^^ ^^PARENT/GUARDIAN SIGNATURE^^

CHILD'S MEDICAL INSURANCE COVERAGE

INSURANCE COMPANY NAME_____ MEMBER/POLICY#_____

POLICY HOLDER'S NAME_____ POLICY HOLDER'S EMPLOYER_____

THE FOLLOWING INFORMATION IS RELEVANT TO MY CHILD'S HEALTH:

ANY ALLERGIES (MEDICATION OR FOOD)? YES / NO IF YES, PLEASE EXPLAIN:_____

_____

ANY MEDICATIONS TAKEN ON A REGULAR BASIS? YES / NO IF YES, PLEASE LIST: _____

_____

ANY ON-GOING MEDICAL PROBLEMS OR CONDITIONS? YES / NO IF YES, PLEASE EXPLAIN: _____

_____

ANY OTHER RELEVANT INFORMATION YOU WOULD WANT A PHYSICIAN TO KNOW? YES / NO

_____

PEDIATRICIAN'S NAME_____ **CONTACT INFO:** _____

DENTIST'S NAME_____ **CONTACT INFO:**_____

PREFERRED HOSPITAL(S) _____

_____ _____
SIGNATURE OF PARENT/GUARDIAN^ DATE SIGNATURE OF PARENT/GUARDIAN^ DATE

CONTACT INFORMATION:

PARENT'S NAME: _____ ***PARENT'S NAME:*** _____
PHONE: _____ ***PHONE:*** _____

_____ _____
WHERE YOU CAN BE REACHED DURING CHILDCARE HOURS *WHERE YOU CAN BE REACHED DURING CHILDCARE HOURS*

All Children of the World Infant Questionnaire Name:_____

Bottle Feedings

Your infant will be receiving a bottle with: ☐ Breast milk ☐ Formula Brand:_____

How many ounces? _____ Approximate number of hour between feedings:_____

What temperature are bottles served: ☐ Room Temperature ☐ On the cool side ☐ On the warm side

☐ Other_____

Does your infant use a pacifier? Yes / No

Sleep Routines

Please note: *We promote and implement guidelines from the "Safe Sleep" campaign. All infants under 12 months must be placed in empty cribs (with only a fitted, snug sheet) on their backs.* ***Any other sleep position requires a written directive or medical order from the infant's health care provider. This directive or medical order must be in the infant's file.***

What is your infant's approximate nap times?_____

How long is a usual nap length? _____

What signs does your child display when getting tired (twirling/tugging on strands of hair, pulling ears)?

_____

What environment does your infant sleep best in: ☐ Silence ☐ Normal Surroundings ☐ Noisy Surroundings

Meals

Is your child on: ☐ Jar Baby Food (Stage 1 / Stage 2 / Stage 3) ☐ Table Food ☐ N/A

Infant Rice Cereal? Yes / No / Do not offer Infant Whole Wheat Cereal? Yes / No / Do not offer

Infant Oatmeal Cereal? Yes / No / Do not offer Infant Barley Cereal? Yes / No / Do not offer

Other:_____

What time do you do your feedings? _____

List what foods have been introduced: _____

_____

Any food allergies or eating difficulties? Yes / No Explain: _____

What are your child's favorite foods? _____

What foods does your child refuses to eat? _____

General

What activities does your infant enjoy? (infant swing, infant bouncy seat, infant busy seat, etc.)_____

_____

Does your infant have any fears?_____

Please add any additional comments which you feel will help us know your child better..._____

_____

_____

MEDICATION / TREATMENT AUTHORIZATION/PERMISSION

Dear Parents:

It is essential that I take precaution regarding the administration of medication to children. If your child has a chronic or non-communicable disease, I may administer medication under the conditions of WAC's 170-296A-3315, 3325, 3375, 3425, 3450, 3475, 3525 and 3550:

1. All medications must be administered only on the written approval of a parent or guardian and be given to the child by Deborah Thurber or a qualified primary staff person.
2. **Non-prescription medications** with this written parent authorization can be given only at the dose, duration and method of administration specified on the manufacturer's label for the child's age or weight. If "consult your physician" is the direction, medication dosage must be approved by a physician or registered nurse and must be in writing. ***Medications must be stored in their original containers.***
3. These medications are stored either in a locked container or cabinet until used or inaccessible to children.

Child's name:_____

Medical issue:_____ to prevent and/or treat Diaper Rash_____

☐ I accept the listed medication supplied by **provider**: ____A+ D Ointment® or Desitin ®Diaper Rash Cream___ ____

☐ Prefer provider use the parent supplied medication listed here: _____

Comments or specific instructions:

Medical issue:_____ to help preserve and protect skin from diaper rashes between changes_____

☐ I accept the listed medication supplied by **provider:** _____Johnson's Baby Pure Cornstarch Powder (talc free)____

☐ Prefer provider use the parent supplied medication listed here: _____

Comments or specific instructions:

Medical issue:_____

Name of medication:_____
(^insert medication you, the parent, will supply^)

Comments or specific instructions

I authorize Deborah Thurber or a qualified staff person to administer the above medication by these written specifications.

Signature: _____ **Date:** _____
(Parent / Guardian)

Note: This document expires 90 days from date above.