GB great beginnings
CHILD DEVELOPMENT AND DAY CARE CENTER

We appreciate you choosing Great Beginnings for your family's child care need. The following forms are ALL REQUIRED prior to enrolling your child at GB! Please let us know if you have any questions or need assistance filling out them out! Thank you!

___ Information Sheet

___ Agreement form

___ Health Information

___ Milk Statement

___ Chronic Conditions

___ Power of Attorney—Childs file copy

___ Grab and Go Emergency Information Sheet

___ Subsidy form

___ Parent Orientation (Read the Parent handbook)

___ Photo release and Comments

___ Immunization Forms (or EXEMPT forms)

_____

Parent Signature Date

** ALL forms need a signature, even if it is NOT APPLICAPLE

INFORMATION SHEET

_____
(Child's first name) (Full middle name) (Last name)

_____ _____
(Name you would like child to learn) (Date of birth)

_____
(Residence street address) (City) (State) (Zip)

_____
(Parent #1 [or legal guardian] name & complete residence address)

_____
(Parent #1 Employer & Phone) (Cell Phone & CARRIER) (Landline/Other Phone)
This needs to be a working contact for you. We NEED to be able to reach you immediately. Voicemail MUST be set up and able to receive messages. Voicemail must be answered within 10 minutes, or we will call Emergency Contacts.

_____
(Parent #2 [or legal guardian] name & complete residence address)

_____
(Parent #2 Employer & Phone) (Cell Phone & CARRIER) (Landline/Other Phone)
This needs to be a working contact for you. We NEED to be able to reach you immediately. Voicemail MUST be set up and able to receive messages. Voicemail must be answered within 10 minutes, or we will call Emergency Contacts.

_____
(Names and ages of siblings)

NAMES/ADDRESSES/PHONE OF PERSONS TO BE CONTACTED IN EMERGENCY IF PARENT IS NOT AVAILABLE OR CANNOT BE CONTACTED (prefer one relative and one friend)

_____
(Name) (Address) (Cell / landline phone)

_____
(Relationship to child) (Cell phone) (Work phone)

_____
(Name) (Address) (Cell / landline phone)

_____
(Relationship to child) (Cell phone) (Work phone)

What source(s) prompted you to first call or visit our Center? _____

_____

I CERTIFY THAT THE INFORMATION GIVEN ON THE INFORMATION SHEET IS ACCURATE AND I WILL NOTIFY GREAT BEGINNINGS IN THE EVENT THAT ANY CHANGES OCCUR.

_____
(Signature of parent or guardian) (Date)

AGREEMENT FORM

_____ (Child's name)

_____ (Days child will attend)

_____ (Admission date)

_____ (Withdrawal date)

The undersigned parent and/or legal guardian agrees to pay Great Beginnings Child Development & Day Care Center the current Registration Fee and the current monthly charges for each month the child is in care and until the child is officially withdrawn from the program. This fee will include the costs of care, developmental program, snacks. Lunches and transportation to and from Great Beginnings Child Development & Day Care Center will be provided by the parent.

I hereby state that I have read and understand and agree to comply with the rules and regulations of Great Beginnings Child Development & Day Care Center regarding fees, credits, attendance, health, parking, clothing, plan for disaster and emergencies, and all other items specified in the Parent Handbook issued by the school prior to enrollment. I am aware of all of the scheduled holidays. I further agree to notify Great Beginnings Child Development & Day Care Center of withdrawal at least two weeks in advance or know that I will be billed for those two weeks.

I UNDERSTAND THAT MY CHILD WILL NOT BE RELEASED TO ANYONE NOT LISTED ON THE INFORMATION SHEET (UNDER EMERGENCY CONTACTS) UNLESS THEY ARE IDENTIFIED BELOW OR PRIOR WRITTEN AND/OR VERBAL PERMISSION IS GRANTED BY THE PERSON(S) WHOSE SIGNATURE APPEARS BELOW.

_____
(Name) (Address) (Landline phone)

_____
(Relationship to child) (Cell Phone) (Work phone)

_____
(Name) (Address) (Landline phone)

_____
(Relationship to child) (Cell Phone) (Work phone)

_____
(Name) (Address) (Landline phone)

_____
(Relationship to child) (Cell Phone) (Work phone)

_____
(Name) (Address) (Landline phone)

_____
(Relationship to child) (Cell Phone) (Work phone)

I CERTIFY THAT THE INFORMATION GIVEN ON THE INFORMATION SHEET IS ACCURATE AND I WILL NOTIFY GREAT BEGINNINGS IN THE EVENT THAT ANY CHANGES OCCUR.

_____
(Signature of parent or guardian) (Date)

HEALTH INFORMATION

_____
(Name of child)

HAS HAD:

_____Measles _____Rheumatic Fever _____Mumps _____Chicken Pox
_____3 day Measles _____Whooping Cough _____Scarlet Fever _____Scarlatina

DOES OR HAS THE CHILD HAD:	**Yes**	**No**	**If yes, give dates & describe:**
Asthma	___	___	_____
Allergies (food, drug, etc.)	___	___	_____
Convulsions, fainting	___	___	_____
Sprains, breaks, dislocations	___	___	_____
Operations	___	___	_____
Hospitalization	___	___	_____
Heart disease	___	___	_____
Strep Throat	___	___	_____
Serious injury	___	___	_____
Ear infections	___	___	_____
Urinary tract infections	___	___	_____
Vision or hearing loss	___	___	_____

Any special health or dietary concerns, visible birth marks, developmental concerns, life threatening medical conditions or current medications used that we should know about:
_____

_____

_____

_____

Date of last physical examination _____
(WA State requires that all children have a physical check-up within a year of entering this Center)

_____
(Physician's name) (Address) (Phone)

Date of last dental examination _____

_____
(Dentist's name) (Address) (Phone)

__X__Dental care and tooth brushing will be done at home with the child's parents and not at school.

_____
(Parent Signature) (Date)

GREAT BEGINNINGS CHILD DEVELOPMENT AND DAY CARE CENTER
Milk Statement

As the parent/guardian of _____, I choose to limit his/her intake of cow's milk. When the Center serves cow's milk as a component of the snack program, I will provide (in a labeled thermos), a non- dairy milk alternative of my choosing (or—*if under 24 months*—of my health care provider's choosing).

Child's Information:

_____ _____
(Child's name) (Date of Birth)

_____ _____
(Parent's name) (Date)

_____
(Parent's signature)

Health Care Provider Information: ***(Required if child is under 24 months)***

_____ _____
(Name of Health Care Provider) (Title)

_____ _____
(Address) (City, State, Zip)

_____ _____
(Phone number) (Date)

_____ _____
(Health Care Provider Signature) (Non-dairy milk alternative)

If your child is OK to have the 1% OR 2% cows milk (non-organic) we serve, please sign below.

_____
(Parent Signature) (Date)

FORM FOR CHILDREN WITH CHRONIC CONDITIONS

Child's Name _____ Medication _____

Condition that requires _____ Start & stop date (not to exceed 6 months)_____

Symptoms to look for when deciding to administer medications:

1. _____
2. _____
3. _____
4. _____
5. _____

Symptoms to look for when deciding to call parent:

1. _____
2. _____
3. _____
4. _____
5. _____

Symptoms that may worsen condition and expected side effects:

1. _____
2. _____
3. _____
4. _____
5. _____

Parent contact information:

1. _____ 2._____
_____ _____

Parent Signature(s)
_____

Physician contact information:
1._____
_____

Other emergency contact:
2._____
_____

Physician Signature_____

PLEASE NOTE THAT THE SAME GENERAL EMERGENCY PROCEDURES
APPLY AS IS STATED IN THE PARENT HANDBOOK.

_____

(Parent Signature if NOT APPLICABLE to child) (Date)

LIMITED POWER OF ATTORNEY FOR MEDICAL ATTENTION
(CHILD'S FILE COPY)

_____
(Child's first name) (Middle initial) (Last name)

To Whom It May Concern:
This is to certify that *Great Beginnings Child Development & Day Care Center* and their responsible parties have the permission of the undersigned to authorize necessary emergency First Aid, transportation to hospital by ambulance, medical care by the attending physician, or others he/she may choose (including emergency surgery), in case of accidental injury, ingestion or illness.

The undersigned accepts all financial responsibility for necessary treatment and services.

_____
(Street address) (City) (State) (Zip)

_____ _____ _____
(Parent #1 contact phone) (Parent #2 contact phone) (Landline phone)

_____
(Employer name) (Address) (Phone)

_____
(Insurance Company) (Plan #) (Policy/membership #)

_____
(Physician name) (Address) (Phone)

_____
(Allergies – or anything you need the attending physician to know)

_____
(Name of parent or guardian – PLEASE PRINT)

_____
(Signature of parent or guardian) (Witness) (Date)

CHILD/PARENT INFORMATION FOR EMERGENCY
"GRAB AND GO" EMERGENCY BAG

CHILD'S INFORMATION	
Child's Full Name	
Date Of Birth	
Address	
Current Medications	
Special Needs/Instructions	
Physician Name/phone	
PARENT / GUARDIAN INFORMATION	
Full Name	
Relationship to child	
Address	
Phone Number(s)	
Email Address(es)	
Place of Employment	
PARENT / GUARDIAN INFORMATION	
Full Name	
Relationship to child	
Address	
Phone Number(s)	
Email Address(es)	
Place of Employment	
OTHER CONTACTS FOR PICK-UP	
Name and phone number	
Name and phone number	
OUT OF AREA CONTACT	
Name and phone number	

STATE SUBSIDY PROGRAM FAMILIES

(Working connections, Seasonal, Employed Foster Parent, CPS, Child Welfare, etc.)

To parents on any subsidy program for Child Care,

We at Great Beginnings are allowed to care for your child(ren) at our Center under guidelines provided to us by WA State agencies.

Some of the stipulations that we have for families receiving subsidies are:

- We only accept children who are authorized for full time, full day care.
- Child(ren) may begin care only AFTER we receive paperwork or a phone call from the State agency.
- Families that miss more than 5 days per month could be asked to leave.
- Child care will be provided ONLY if you need care for 5 or more hours per day. This means that if a child is not at GB for 5 hours per day, we will not be able to provide services for your family.
- The State DOES NOT pay for lunches, diapers, wipes, latenesses, etc. Parents have sole responsibility for payment of these EXTRA services.

The undersigned parents also agree to the following:

- Families must maintain their eligibility with the State.
- Parent(s) must be diligent about making sure the child(ren) are signed in and out on a daily basis.
- Parents will arrive with their child(ren) at GB no later than 9:30 am unless prior arrangements are made with the Director.
- Parents will pay their monthly co-payment to Great Beginnings by the tenth day of the month. If co-payment is not received by this day, you will receive notice that the 15th will be the last day that the Center can provide care for your child (ren). If you decide to make payment before the 15th, a late fee of $10.00 will be assessed.

_____

(Child)

_____

(Signature) (Date)

_____

(Parent Signature if NOT APPLICABLE to child) (Date)

Parent Orientation Check List

I have received written policy and procedure information via a "Parent Handbook" with the following information:

___Statement of Purpose

___Philosophy

___Physical Facility

___Program and Services

___Daily Schedule

___Hours of Operation

___Parking

___Arrival/Pick up (Release info)

___What To Wear

___What To Bring

___Additional For Toddlers

___Things the Center Could Use

___Birthdays

___Personal Belongings

___ClassTag*

___Transportation/Extra Curricular

___Enrollment Procedures

___Full/Part Time Enrollment

___Rates/Absences

___Calendar Of Closings

___Visitor Privileges

___Staff

___Clover Park TC Affiliation

___Evacuation Plan

___Fire/Disaster Drills

___Discipline

___Health Care Plan

___Disaster Plan

___Withdrawals

*Upon enrollment at Great Beginnings each parent/guardian will be required to join ClassTag. This is a notification system/app we use to notify parents of emergency situations, inclement weather, early closures etc. Parents/Guardians will be sent a code that will link you to Great Beginnings ClassTag account and enable us to contact you should these situations arise.

In addition, I have had any questions and/or concerns addressed with the Director(s) including, but not limited to, policies and procedures, center philosophies, program, facilities, parent conferences, parent volunteering, special needs, etc.

_____ _____

(Signature) (Date)

Child(ren)s name(s)_____

WAC 110-300-0085
Requires us to give parents the opportunity to share the following:
(Please note that sharing of information on this page is OPTIONAL)

Is there anything you would like us to know about: **Child's name**_____

-Your child's development _____

_____

_____

-Your child's behavior _____

_____

_____

-Your child's health _____

_____

_____

-Your child's linguistics / language_____

_____

_____

-Your child's culture / beliefs _____

_____

_____

-Your child's social development_____

_____

_____

-Your family's routines / events / parenting style_____

_____

_____

Please allow ample time for the Center to arrange the following:
ANY time that you have questions, concerns, etc, PLEASE do not hesitate to contact us at 360-352-7236.
The Center will provide a progress report to you upon request.
The Center or the family may request a conference at any time.
Families have an opportunity to share their culture, language, knowledge, etc…. Any time upon request.

PHOTO RELEASE AUTHORIZATION FORM

From time to time, photos will be taken of the children, activities, etc. We, at Great Beginnings, use these photos for learning purposes and to enhance our environment.

Also, Great Beginnings CD & DCC would like to use some of these photos for news releases, the Center's website, videos, slide presentations, marketing purposes, etc.

At certain times of the year, at the discretion of Great Beginnings, photographers will take photos of the children for resale to you, the parent.

_____
(Child's name)

_____ Yes, I grant permission for Great Beginnings CD & DCC to use my child's photo for advertising and promotions for the Center.

_____ No, please do not use my child's photo for anything outside of the Center.

_____
(Parent's signature)

_____
(Date)

PARENT COMMENTS FOR POSSIBLE PUBLICATION

RATING : ☆☆☆☆☆

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
(feel free to continue in the back if needed)

_____
(Parent's name PRINTED)
We will only use first name and last initial

_____
(Parent's Signature)

_____
(Date)

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ☐ Yes ☐ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY): **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ☐ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity
Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

☐ a verified history of Varicella (Chickenpox).

☐ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

☐ Diphtheria	☐ Mumps	☐ Other:
☐ Hepatitis A	☐ Polio	_____
☐ Hepatitis B	☐ Rubella	_____
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

RETURNING FAMILIES AND/OR POTENTIAL FAMILIES

In the past 72 hours (3 days), has anyone in your family had any of the following symptoms ---

YES NO A cough

YES NO Shortness of breath or difficulty breathing

YES NO A fever of 100 degrees or higher

YES NO A sore throat

YES NO Chills

YES NO New loss of taste or smell

YES NO Muscle or body aches

YES NO Nausea / vomiting / diarrhea

YES NO Congestion / runny nose (not related to seasonal allergy)

YES NO Unusual fatigue

YES NO Been in contact with anyone either suspected or confirmed COVID-19

YES NO Had any fever or pain reducing medication

_____ _____
Name of Parent/Guardian Name of Child

_____ _____
Signature of Parent/Guardian Date