Childcare

Enrollment Packet

This Manual is the property of Playful Minds, LLC

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Enrollment Form

Child information

Child's Name:		Primary Language:	
Street:		Skin Color:	
City/State/Zip:		Hair Color:	
Date of Birth:		Eye Color:	
Age at Admission:		Identifying Marks:	
Admission Date:		Height:	
		Weight:	

Parent information

Parent/Guardian 1:		Parent/Guardian 2:	
Relationship to Child:		Relationship to Child:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone Number*:		Phone Number*:	
Personal Email:		Personal Email:	
Employer:		Employer:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Bus. Phone Number:		Bus. Phone Number:	
Work Hours:		Work Hours:	

This should be the phone number that is used for your primary contact purposes & where we can reach you quickly.

School age children's current school information

Current School:		Phone Number:	
Street:		City/State/Zip:	

First Aid and Medical Consent Form

Child's name: **Date of birth:**

Home street: **City/town:**

Phone number:

Parent/guardian contact information

List names in the order in which you would like us to contact first.

Name (1): Phone number:

Home street: City/town:

Name (2): Phone number:

Home street: City/town:

Emergency contact persons

List names in the order in which you would like us to contact first.

Name (1): Phone number:

Home street: City/town:

Name (2): Phone number:

Home street: City/town:

Pediatrician or person that provides health care to your child

Name: Phone number:

Home street: City/town:

Allergies/chronic health conditions

Insurance information (optional)

Company: Policy /or member :

Emergency medical treatment authorization

I hereby give the Playful Minds permission to administer first aid/CPR to my child or take my child to a hospital for treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent name: **Date:**

Parent signature:

Tuition payment & child schedule contract

This agreement contains the financial terms that are agreed to between the parent and Playful Minds, LLC for the care of their child.

Child's Name:

Date of Birth:

Program:

Classroom:

Contract Start Date:

Contract End Date:

Parent's Name:

Street:

City/State/Zip:

Phone:

Email:

The childcare schedule agreed upon for your child at Playful Minds is:

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop-Off Time:					
Pick-Up Time:					

Enrollment Changes:

Two weeks' in advance notice (in writing to Playful Minds) is required if you want to make any changes to your child's enrollment,

Deposit: The first week s tuition and security deposit pay ments are due before the child s entry into the program.

Payments. *There is no discount or deduction from the tuition for student absences, family vacations, inclement weather days, holidays, teacher training days, etc.* Tuition can ONL be paid through the right heel (https //mybrightwheel.com/) tuition payment section. *Playful Minds DOES NOT accept checks, money orders, or credit cards directly.*

Payment frequency. Parents have the option to pay tuition either weekly or monthly however, the payment schedule cannot deviate from the option indicated on this form.

Payment schedule. eekly payments are due every Friday before the week the payment is being made for. Monthly payments are due on the 1st of each month.

Late payment fees. Payments are considered late after 3 days. If payments are late, a 10.00 fee is assessed and will automatically be added to the parent s account. Payments later than one week will result in suspending your child until the past due balance is paid in full. Payments are to be made regardless of absenteeism.

Late pickup fee. A parent late picking up their child from Playful Minds will be charged 10.00 for the first 15 minutes and 5.00 for each additional 5 minutes or portion thereof. This fee is due at time of pick up or no later than the following day.

NEFW Voucher Eligibility. Please refer to vouchers for contract amount and dates of service. Any period of time not covered by a NEF voucher will be billed at private rates. **Parent initials:** ______

The parent selected the following payment schedule:

______ **Weekly** ______ **Monthly**

PAYMENTS

Registration fee: (non-refundable) $

Deposit: (non-refundable, applied to 1st week) $

Tuition payment: $

Parent Signature:

Date:

Small Group & Large Group Transportation Plan & Authorization

Refer to First Aid and Medical Consent Form for specific release information.

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

TRANSPORT #1

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

Complete the following 2 sections if the child will be transported to/from more than one location or by additional methods/person(s).

TRANSPORT #2

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

TRANSPORT #3

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

My child will arrive at the program by:

- Parent drop off
- Supervised walk
- Unsupervised walk
- Public/private van
- Program bus/van
- Contract van
- Private transportation arraigned by parent
- Other

Parent name: **Date:**

Parent signature:

Permission/Release Form

Child Name: **Date of Birth:**

I understand and I am aware that my child might be involved with the following:

Yes **No** Photographs of my child may be taken during center hours and used for publicity.

Yes **No** Student teachers in the course of their studies may observe my child s classroom.

Yes **No** Member(s) of various agencies may be providing services to other children in my child s class. I give permission for my child to be in the same class while these observations/services are being provided to other children. I understand that if there are any concerns about my child, I will be notified immediately.

Exception to giving permission:

I understand in the event that my family has been involvement with the Department of Children and Families (DCF), your child may be interviewed by social worker while in our care.

Additional written permission:

With the exception of the DCF, a signed written approval will be required for any interview with other agencies/organizations.

With my signature, I give my permission for general observation to be completed as outlined above. I understand the circumstances in which I will be contacted for a separate written approval.

Parent name: **Date:**

Parent signature:

Permission to Leave Premises

Child Name: **Date of Birth:**

I give Playful Minds, LLC permission to take my child off premises to close-by destinations. Activities may include nature walks, walks to the local park, and the like. These activities are planned and incorporated into the classroom schedule.

Additional written permission:

I understand that if a field trip is planned and the children are being taken to further destinations (such as the zoo or a farm), I will be asked to complete an addition consent form.

With my signature, I give my permission my child to be taken to close-by destinations as outlined above. I understand the circumstances in which I will be contacted for a separate written approval.

Parent name: **Date:**

Parent signature:

Parent involvement

Child Name: **Date of Birth:**

Please refer to the Parent Handbook for additional information about parent involvement which includes information about parental rights and ways to be involved and to provide input to the program.

Parent Grievance Procedure

We value parent involvement as an essential part of our program. We also recognize that on occasion parents/guardians have a grievance in relation to our program and/or procedures. As a parent/guardian, you have the right to offer suggestions/feedback about the program and policies. However, in efforts to provide quality care and services to our families we ask that you adhere to the following procedures:

- Be sure that your child is signed in and accounted for by the classroom teacher(s).
- Direct your concerns and/or complaint to the Program Director.
- Request a private meeting with the Program Director to discuss the issues at hand.

Emotional outbursts that appear to be threatening in nature will not be tolerated. This behavior can be grounds for immediate termination without notice of your child's enrollment.

If you have spoken with the Program Director and still feel that the issues is not resolved, please contact Paige Thompson-Westcott at the main office by calling 413-636-5696.

Incidents Involving Parents

An "incident" is deemed to be any event in which the policies of the program are not being adhered to and/or the safety of the staff and/or children is perceived to be in jeopardy. When such an incident occurs, staff are to immediately implement the following procedure.

- Staff inform the Program Director (or the Lead Teacher in the Program Directors absence) of the incident.
- The Program Director contacts the Main Office for direction in the appropriate action to be taken.
- If the incident is of a severe and/or dangerous nature, staff will immediately contact the local Police Department for support in the matter at hand. Staff is to follow up with the Program Director to inform of actions taken.
- Any violent outburst or displays of aggressive behavior towards staff by parents will result in immediate termination of your child's enrollment.

Parent name: **Date:**

Parent signature:

Summer "Hold Placement" Contract

This agreement contains the financial terms that are agreed to between the parent and Playful Minds, LLC to hold classroom placement during the summer months.

Child's name:		**Parent name:**	
Date of birth:		**Street:**	
Program:		**City/state/zip:**	
Classroom:		**Phone:**	
Hold start date:		**Email:**	

STEP 1: The Summer Hold Placement payment of $500.00 must be made no later than the 1st week of June. If payment is not received by this timeline, your child's placement will be made available for newly enrolling children.

STEP 2: The first week of tuition must be received no later than the 2nd week of August for your child to return to the program in September.

Summer "Hold Placement" payment due: **$ 500.00**

Payment received on:

Signature: **Date:**

Permission to apply products

Child name: **Date of birth:**

Product Requirements

- All products are provided by the parent and given the classroom teacher.
- All products must be in ointment or cream form. (Aerosol spray is NOT allowed.)
- All product packages must be labeled with the child s name.

Product Types

I give Playful Minds Learning Center, LLC permission to apply the following skin protection products to my child.

Yes	**No**	Sunscreen of SPF 15 or higher.
Yes	**No**	Topical bug repellent.
Yes	**No**	Hand sanitizer (60% alcohol or greater) – Communicable disease prevention: COVID-19. *Hand sanitizer is provided by PMLC.*

Parent name: **Date:**

Parent signature:

Oral Health Non-Participation

You do not need to fill out this form to have your child participate in tooth brushing while they are in childcare.

Child name: **Date of birth:**

Purpose of Oral Health Program

In January 2010, the Massachusetts Department of Early Education and Care (EEC) issued new regulations [606 CMR 7.11(110] for child care programs that include a requirement that educators assist children with brushing their teeth if children are in their care for more than four hours or if they have a meal while in care. This regulation is intended to:

- Help children learn about the importance of good oral health.
- Provide information and resources regarding good oral health to childcare programs and families.
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

All EEC licensed programs must comply with this regulation. However, parents may choose that their child not participate in tooth brushing while present at the childcare program.

Option for non-participation

I do not want my child to brush his/her teeth while at the childcare program. I understand a new form will need to be completed each year. And a separate form needs to be completed for each of my children if more than one of them in is the childcare program.

Parent name: **Date:**

Parent signature:

Little Body Form

Please identify any marks on your child, such as birthmarks, beauty marks, scars, skin discoloration, etc.

Child name: ______________________ **Date of birth:** ____________

My child has identifying marks on his/her body. **Yes** **No**

- If No, go to the signature portion of this form.
- If Yes, indicate the location of the marks and give an explanation below. Then go to the signature portion of this form.

FRONT-SIDE OF BODY **Mark X where front identifying marks are located**	BACK-SIDE OF BODY **Mark X where back identifying marks are located**
Explain front-side identifying marks	**Explain back-side identifying marks**

Parent name: **Date:**

Parent signature:

Developmental History & Background Information

Regulations for childcare facilities requires this information to be on file to address the needs of children while in care.

Child name: **Date of birth:**

The (*) indicates questions specifically for infant and toddlers.

Developmental History

Age child began: Sitting: Crawling: Walking: Talking:

***Does your child pull up? Yes No *Does your child crawl? Yes No**

***Does your child walk with support? Yes No**

Any speech difficulties? Yes No If yes,describe:

List specific words child uses to describe needs:

Language spoken at home: *Any history of colic? Yes No

***Does your child use a pacifier? Yes No Does your chld suck thumb? Yes No**

***When?**

***Does your child have a fussy time? Yes No *When?**

***How do you handle fussy time?**

Health

Any known complications at birth? Yes No If yes, describe:

Serious illnesses or hospitalizations? Yes No If yes, describe:

Serious conditions, disabilities? Yes No If yes, describe:

Allergies, i.e., asthma, hay fever, insect bites, medicines, food reactions? Yes No

If yes, describe:

Regular medications? Yes No If yes, describe:

Eating Habits

Are there any difficulties or special circumstances eating? Yes No

If yes, describe:

***Is infant on a special formula ? Yes No If yes, describe:**

Has favorite foods? Yes No If yes, describe:

Foods are refused: Yes No If yes, describe

***Is child fed while held on lap? Yes No *High-chair? Yes No**

***Does your child eat with spoon? Yes No *Fork? Yes No *Hands? Yes No**

Toilet Habits

***Are disposable cloth diapers used? Yes No *Frequent occurrence of diaper rash? Yes No**

Do you use oil? Yes No *Powder? Yes No * Lotion? Yes No *Other?

*Are bowel movements regular? Yes No How many per day?

*Is there a problem with diarrhea? Yes No Constipation? Yes No

*Toilet training attempted? Yes No *Describe any particular toileting procedure to be used for your child at the center?

*Indicate what type of seating is used at home for toileting below:

*Potty chair? Yes No *Special child seat? Yes No *Regular toilet seat? Yes No

*How does your child indicate bathroom needs (include specific words)?

Is your child reluctant to use the bathroom? Yes No Does your child have accidents? Yes No

Sleeping Habits

*Does your child sleep in a crib? Yes No Bed? Yes No

Does your child become tired or nap during the day? Yes No

If yes, when and how long?

When does your child go to bed at night? Get up in the morning?

Describe any special characteristics or needs (stuffed animal, story, mood on walking), etc.:

********* Please note: The American Academy of Pediatric has determined that placing a baby on his/her back reduces the risk of Sudden Infant Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with the caregiver. ***********

Social Relationships

How would you describe your child?

Previous experience with other children/day care:

Reaction to strangers: Able to play alone: Yes No

Favorite toys and activities:

Fears (the dark, animals, etc.):

How do you comfort your child?

What is the method of behavior management/discipline at home?

What would you like your child to gain from this childcare experience?

Daily Schedule

Describe your child's schedule on a typical day.

Wake up time: ___________ Time taken out of crib/comes out of bed in the morning:

Eating times: Nap time(s):

Fussy times: Play time(s):

Toilet habits: **Night bedtime:**

Other:

Is there anything else we should know about your child?

Parent name: **Date:**

Parent signature:

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.	Signature of Parent/Guardian Date

ED 191 REV. 3/2015 C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________ Birth Date ____________ (mm/dd/yyyy) Date of Exam ____________ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_______/ _____ (Annually at 3 – 5 years)

Screenings

*Vision Screening	*Hearing Screening	*Anemia: at 9 to 12 months and 2 years
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs) ❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right / Left With glasses 20/ 20/ Without glasses 20/ 20/ ❑ Unable to assess ❑ Referral made to: __________	❑ EPSDT Subjective Screen Completed (Birth to 4 yrs) ❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right / Left ❑ Pass ❑ Pass ❑ Fail ❑ Fail ❑ Unable to assess ❑ Referral made to: __________	*Hgb/Hct: *Date *Lead: at 1 and 2 years; if no result screen between 25 – 72 months History of Lead level $\geq 5\mu g/dL$ ❑ No ❑ Yes
*TB: High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: ______ Results: __________ Treatment: __________	*Dental Concerns ❑ No ❑ Yes ❑ Referral made to: __________ Has this child received dental care in the last 6 months? ❑ No ❑ Yes	*Result/Level: *Date Other:

*Developmental Assessment: (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
If yes, please provide a copy of an ***Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: __________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
If yes, please provide a copy of the ***Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** __________

Seizures ❑ No ❑ Yes: Type: __________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*__________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Child's Name: ______________________ **Birth Date:** ______________ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) ______________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) ______________________
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

____
Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Acknowledgment of receipt of Parent Handbook

Child name: **Street:**

Parent name: **City, State:**

The Playful Minds Learning Center LLC (PFML) Parent Handbook has been made available to me and was available for download on the PFML website, and that, if I am not able to access the website, I had the option of receiving a printed copy.

I understand the policies in this handbook are sub ect to change to maintain compliance with current and future issuing of local, state, and federal regulation. And that, changes in the handbook may also occur at the authori ation of the owner to indicate improvements in procedures, information sharing with staff and families, and other reasons, provided such changes do not violate local, state, and federal law.

I understand my child s enrollment at PFML could be terminated if any problems listed in the *Termination and Suspension* (but not limited to) policy described herein occur.

I acknowledge that PFML staff discussed the policies in the handbook with me. I was given the time to ask questions and have them answered to my ability to understand them.

I, the Parent/Guardian, have read, understand, and agree to follow the policies and procedures required of me in this handbook.

Parent signature: **Date:**

I, the Parent/Guardian, acknowledge that PFML staff discussed the Child Guidance policy in this handbook with me. I was given the time to ask questions and have them answered to my ability to understand them.

Parent signature: **Date:**

For INFANT FORMS,
please proceed to the following 3 pages.

Infant

Enrollment Forms

Breast Feeding Policy

Child name: **Date of birth:**

We support breastfeeding mothers by:

- **Accepting, storing, and serving expressed milk for feedings.**
- **Accepting milk in ready-to-feed sanitary containers labeled with the infant's name and the date and store in a refrigerator.**
- **Keeping the milk for no longer than 3-months, frozen.**
- **Keeping the milk for no longer than 48 hours, not frozen.**
- **Keeping the milk for no longer than 24 hours, if previously frozen – then thawed.**
- **Gently mixing, not sharking, the milk before feeding to preserve the human milk's special infection-fight and nutritional components.**
- **Coordinating feedings with the infant's mother.**
- **Maintaining an open-door policy and inviting the mother to feed whenever she is available.**
- **Providing a comfortable chair for the mother to breastfeed, and the chair can be turned in a way for more privacy.**
- **Educating mothers about the benefits of breastfeeding, if possible.**

My child is breastfed, and I understand this policy.
My child is formula-fed. This policy does not apply to my family.

Signature: **Date:**

Infant Sleep Policy

Child name: Date of birth:

The following are the measures taken by Playful Minds to reduce the risk of Sudden Infant Death Syndrome (SIDS):

- Every child under one year of age is placed on their back to sleep. (The only exception will be if the child's physical provides written directions that indicate otherwise.
- The crib mattress is a firm surface.
- Faulty, broken, or defective cribs are fixed and replaced promptly.
- No pillows, comforters, blankets, stuffed toys, infant seats, or other items are placed in the child's crib at any time.
- Teachers place themselves that direct supervision of all sleeping infants is guaranteed.
- Sleeping infants are removed from car seats, booster seats, strollers, and swings and are placed in their assigned crib and placed on their back to sleep.
- At twelve months of age, the infant is transitioned to a nap-mat for sleeping.

The following are the sleep procedures for children over age one:

- A nap-mat is provided and only used by that child. This mat is labeled with the assigned child's name.
- All mats are cleaned and sanitized weekly.
- Parents are responsible for providing a sheet and blanket for their child's mat. The nap items are sent home every Friday to be washed and returned with the child on the following Monday.
- Mats are placed 3-feet apart from each other to ensure every child has enough personal sleep space.
- After a child rests for 45-minutes and is not sleeping, quiet toys, books, and puzzles are offered.

Signature: Date:

Infant Information Form

Child name: Date of birth:

Birth

Pre-Mature Delivery: Yes No
Full-Term Delivery: Yes No

Birth Weight: Lb. oz.

Breast Fed: Yes No
Formula Fed: Yes No

Bottle feeding

Does child take bottle? Yes No
Does child hold own bottle? Yes No

Is the bottle warmed? Yes No

Food

Does child eat baby food? Yes No
Does child eat table foods? Yes No
If yes to baby or table food, explain:

Food likes:
Food dislikes:
Food ALLERGIES:

Meals & snacks

	Time	Food type(s) & amount
Breakfast:		
Lunch:		
Snack:		

Comforting

Does child take a pacifier? Yes No
If yes, when:

Sleeping

Does child need special blanket, stuffed animal, etc.to sleep? Yes No
If yes, what?

Time of morning nap: Time of afternoon nap:

Signature: Date: