Enrollment Form

*All forms must be completed and on file at the Center **on or before** your child's first day of attendance.*

Today's Date: ___/___/___ | (Office use only) Enrollment date: ___/___/___

Child's Name: _____ Child's Social Security # ____-___-____
(First) (Middle) (Last)

Child's Nickname: _____ Birth date: ___/___/___ Gender: M / F

Please list approximate times the child will usually arrive and depart from the Center:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Departure					

Custodial Parent/Guardian Information

Name: _____
Relationship to child: _____
Home address: _____
(Street address)
_____
(City) (State) (Zip)

Home Phone: _____
Cell Phone: _____
Cell Phone Carrier: _____
(This info is needed for the purpose of messaging w/our ProCare app)
Email: _____
Work hours: from ___:___ to ___:___
Work Phone: _____
Employer: _____

Name: _____
Relationship to child: _____
Home address: _____
(Street address)
_____
(City) (State) (Zip)

Home Phone: _____
Cell Phone: _____
Cell Phone Carrier: _____
(This info is needed for the purpose of messaging w/our ProCare app)
Email: _____
Work hours: from ___:___ to ___:___
Work Phone: _____
Employer: _____

Parents are: ❑ Single ❑ Married ❑ Divorced ❑ Separated
If divorced, who has custody? ❑ Mother ❑ Father ❑ Both ❑ Guardian:
Child's primary residence is with: ❑ Mother ❑ Father ❑ Both ❑ Guardian:
Is the non-custodial parent authorized to pick-up the child? ❑ Yes ❑ No (If no, please provide a copy of court custody papers.)

Emergency Contact Information/Authorized Pick-Up

*Please provide the following information on **at least two** responsible, non-custodial, local persons to contact in an emergency if the parent or guardian cannot be reached. We cannot release a child to anyone without **written** consent from a parent/guardian.*

Name	Relationship to the child	Address* (*Required for emergency contacts)	Work/Cell Phone	Should be called in an emergency	Is authorized to pick up this child
				Yes No	Yes No
				Yes No	Yes No
				Yes No	Yes No

Any person picking up the child who is unknown to Center staff is required to show a picture ID

Medical Information

A copy of your child's immunization record must be on file at the Center.
Records must be updated after each series of immunizations.

Child's Name: ____
(First) (Last)

Name of Child's Physician: ______________________________________
Address: ______________________________ Phone: ______________
(Street address) (City) (State) (Zip)

Name of Child's Dentist: ____
Address: ______________________________ Phone: ______________
(Street address) (City) (State) (Zip)

Please list any allergies (including food, medicinal, seasonal, chemical, etc.) that your child has been diagnosed with. ____
____

Special Diet / Restrictions (vegan, vegetarian, no meat/pork, please be specific)____

Medical History

Please list dates of diagnosis on all that apply: ❑ None apply

___/___/___ Cancer	___/___/___ Hemophilia	___/___/___ Leukemia
___/___/___ Chicken Pox	___/___/___ Hepatitis B	___/___/___ Measles
___/___/___ Defective Heart	___/___/___ Hepatitis C	___/___/___ Mumps
___/___/___ Diabetes	___/___/___ HIV/AIDS	___/___/___ Tuberculosis
___/___/___ Epilepsy	___/___/___ Hypoglycemia	

Please check all that apply:

❑ ADD/ADHD	❑ Frequent colds	❑ Seizures
❑ Bed wetting	❑ Frequent ear infections	❑ Sun sensitivity
❑ Biting	❑ Frequent throat infections	❑ Temper tantrums
❑ Fainting spells	❑ Other: ______________________________	

Emergency Medical/First Aid Consent

I, parent/guardian of ______________________________, authorize
(child's first & last name)

Kiddie Campus to seek emergency medical care for my child. Such care may include transportation to and from the hospital, medical care from a licensed physician in the event that a parent/guardian cannot be reached, as well as first aid treatment by Center staff.

- -

While it is understood that reasonable precautions will be taken by the Center staff to prevent accident or injury to my child while in their care, I will not hold them legally responsible for such accident or injury.

Parent/Guardian Signature: ______________________________ Date: ___/___/___

Parent/Guardian Signature: ______________________________ Date: ___/___/___

Permission/Acknowledgement

Child's Name: _____ _____
(First) (Last)

❑ Yes ❑ No I authorize Kiddie Campus to apply *Equate Kids Sunscreen Continuous Spray – Broad Spectrum SPF 50* sunscreen onto my child as needed for the _____ - _____ school year.

❑ Yes ❑ No I authorize Kiddie Campus to apply *Off! Family Care Insect Repellent* onto my child as needed for the _____ - _____ school year.

❑ Yes ❑ No I authorize my child to be photographed and/or videotaped for promotional uses and special events. I understand that my child's photograph may be viewed in the form of posters, television ads or news stories, and the Center's Facebook page and/or promotional websites.

❑ Yes ❑ No I authorize Kiddie Campus staff to include my child in nature walks outside of the facility.

❑ Yes ❑ No I authorize the Center to post my child's allergy/medical alert in his/her assigned classroom, in the kitchen, and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.

❑ Yes ❑ No I authorize the Center to transport my child in instances of unforeseen emergency situations that require relocation from the Center's facility.

❑ Yes ❑ No I authorize Kiddie Campus to administer Acetaminophen to my child after I have been notified of the need and have given my verbal permission. I understand that I am responsible for providing this and completing a Medication Request Form prior to it being administered.

❑ Yes ❑ No I authorize the Center to administer the Ages and Stages developmental screening to my child for the purpose of determining the progression of my child's skills and milestones. I understand that the results of the screening may indicate that a referral for further evaluation is needed to determine the best course of action to take to ensure my child's developmental needs are being met.

I have received the following information from Kiddie Campus Child Care Center:

❑ Yes ❑ No AR Kids 1st
❑ Yes ❑ No Medical homes for children
❑ Yes ❑ No Positive Parenting Tips
❑ Yes ❑ No MyPlate
❑ Yes ❑ No Stages of Play
❑ Yes ❑ No Facts About Physical Activity
❑ Yes ❑ No Shaken Baby Syndrome (Infants)
❑ Yes ❑ No AR Kindergarten Readiness Indicators (3-5 yrs)

All applicable items are included in your enrollment packet.

❑ I have read and understand the policies and procedures included in Kiddie Campus' Family Handbook for the _____- _____ school year.

❑ I have read and understand Kiddie Campus' Behavior Guidance Policy as it is outlined in the Family Handbook.

❑ I understand that I may request a meeting/conference anytime with my child's teacher and/or the Center's administration to discuss any concerns I have regarding my child.

❑ I understand that DHS Licensing personnel, child maltreatment investigators, law enforcement, and/or AR Better Beginnings evaluators may interview my child for investigative purposes and/or view my child's file in an effort to determine the Center's compliance with licensing and quality standards. I further understand that this does not require parental notice or permission.

❑ I understand that the licensing compliance reports for Kiddie Campus are available to view upon request for the past 3 years.

❑ I understand my child's photograph may be taken by teachers and/or other parents during special events and used for classroom purposes such as cubby labels, wall displays, teacher-made books and portfolios. I further understand that my child's picture may be shared with me through ProCare.

Parent/Guardian Signature: _____ Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___/___/___

When applicable, <u>both</u> custodial parents are <u>required</u> to sign this page.

By signing this page, you are acknowledging consent for, knowledge of, and/or receipt of the above sections that have you have marked.

Developmental Information Survey
Preschool

Child's Name: _____ Birth date: ___/___/___ Today's Date: ___/___/___

Social Information

Child's Siblings: Name: _____ Age: ____ Name: _____ Age: ____
Types & names of family pets:_____
Nationality: _____ Religious preference: _____
Please describe who has cared for your child other than parents? (Please state whether the caregiver was an adult or teenager.) _____
Has the child had prior group play experience? ___No ___ Yes: Please describe: _____
_____

Birth History

Type of birth: Normal: ❑ Yes ❑ No Premature: ❑ No ❑ Yes: How many weeks? _____
Complications? _____
Birth weight: _____ Length: _____ Head circumference: _____
Does your child have any birth marks? ❑ Yes ❑ No If yes, please describe (size & location):
_____

Developmental Information

Age your child began: Sitting up on own _____ Crawling _____ Walking _____
Is your child a good climber? ❑ Yes ❑ No Does s/he fall easily? ❑ Yes ❑ No
Can your child dress him/herself? ❑ Yes ❑ No Undress self? ❑ Yes ❑ No
Age your child began coherent talking: _____ Does s/he use ❑ Words? ❑ Sentences?
What language(s) do you speak with your child at home? _____
Please describe your child's favorite game: _____
Favorite toy/activity: _____
Favorite book/story: _____
Favorite person(s): _____
Does your child have any particular habits (thumb-sucking, nail-biting, etc.)? ❑ No ❑ Yes:
Please describe _____
Does your child have any fears that you know of? ❑ No ❑ Yes: Please describe _____
_____
When your child seems upset or unhappy, what seems to comfort him/her?_____
_____
Please list any allergies (other than food) that your child has (insect bites/stings, medication, etc.) and the type of reaction. *This should **ALSO** be noted on the Medical Report.*
_____
Does your child attempt to hold a pencil correctly? ❑ Yes ❑ No Scissors? ❑ Yes ❑ No
How high can your child count with no mistakes? _____
Does your child recognize the letters in his/her name? ❑ Yes ❑ No

Diapering/Toileting

Is your child toilet trained? ❑ No ❑ Yes: What age for urination: ___What age for BM: ___
Has toilet training been attempted at home? ❑ Yes ❑ No
Will your child be relied on to indicate a need for toileting? ❑ Yes ❑ No
What words does your child use for urination? _____ Bowel Movement? _____
If your child is a boy, how does he prefer to urinate? ❑ Stand ❑ Sit
Please describe any irregularities or anything unusual about your child's urination or bowel movements: _____

***Toilet-trained children are expected to use the bathroom independently. Boys and girls use the same bathroom facility at separate times.*

Behavior

Please describe your child on the scale in the following areas:

Scale: 1 2 3 4 5 6 7 8 9 10
(Seldom Monthly Weekly Daily)

How often does your child tell you no? _____
How often does your child hit or kick you or others? _____
How often does your child bite? _____
How often does your child throw temper tantrums? _____
How well does your child obey instructions from you or other adults? _____

Does your child have any emotional or physical disabilities? ❑ No ❑ Yes: Please describe:

_____

_____

***If teaching staff observe indications of any developmental delay, this will be documented and shared with you, along with contact information for an early childhood professional who is trained to help with the particular delay.*

Please describe your child's personality: _____

_____

_____

Please describe the method of behavior guidance you use at home: _____

_____

_____

How does your child react to this method? _____

_____

_____

Sleeping

What time does your child go to bed at night? _____ Awaken in morning? _____
Does your child take a nap? ❑ No ❑ Yes: How long? _____
What time does s/he sleep? From _____ To _____
Please describe any problems connected to sleep (including nightmares): _____

_____

How do you get your child to sleep? _____

_____

Does your child need a security item? ❑ No ❑ Yes: Please describe _____
Does your child need a pacifier? ❑ No ❑ Yes: What type? _____

Eating

What time does your child usually eat? Breakfast ___:___ Lunch ___:___ Dinner ___:___
Does your child feed him/herself? ❑ No ❑ Yes: ❑With fingers ❑With spoon ❑With fork
What are your child's favorite foods? _____
What foods are refused? _____

List any foods that have caused problems (allergy, choking, etc.):
***These should **ALSO** be noted on the Medical Report*

Food	Describe the problem

Other Information

Please describe any important cultural celebrations that your family participates in: _____

_____

_____

What are some of your goals and dreams for your child? _____

_____

_____

What are some things you hope your child will learn or experience while in our program?

_____

_____

Please list any other important information or concerns that you feel our caregivers should know about:

_____

_____

_____

This page intentionally left blank.

ENROLLMENT, TUITION & OTHER FEES CONTRACT

Child's Name: _____ Birthday: _____/_____/_____

Child's Name: _____ Birthday: _____/_____/_____

Child's Name: _____ Birthday: _____/_____/_____

Fees:

- ❑ Registration Fee of $100 (non-refundable)
- ❑ Operational Fee of $50/month (includes materials, equipment, cleaning, and insurance)
- ❑ Weekly tuition payment of $250.00/week (due on the Friday of the week before services are rendered)

Forms of Payment:

- ❑ ProCare Tuition Express (**Preferred) (Please see information below or pay through ProCare app.)
- ❑ Check
- ❑ DHS Childcare Assistance/Essential Workers/TEA program

DHS will pay $_____ per week. Parent/Guardian co-pay is $_____ per week.

Operational fee is $50 per month.

My total payment based on the above amounts is $_____ per week.

I agree to pay this using the above-marked method.

Please initial each statement:

____ I agree to drop off my child by 10:00am each day and understand that if I am later than this time my child will not be able to stay at the Center without prior consent from a member of the Leadership Team.

____ I agree to provide extra clothes, diapers and wipes for my child and replenish them when needed.

____ I understand that Kiddie Campus provides formula, milk, and baby food for all infants. If my child does not use the brand that the Center provides, I agree that I must provide them myself.

____ I agree to be responsible to pay for the agreed upon tuition payments and fees stated in this contract.

____ I agree to pay the tuition payment by Friday prior to the week in which services are rendered.

____ I understand that if payment is not made as scheduled, I am subject to a late fee of $10.00.

____ I understand I am subject to a $35.00 fee assessed for a returned payment. If more than one payment is returned, this method of payment will no longer be accepted and payment must therefore be made by bank check, or money order.

____ Late or returned payments more than four times in one calendar year may be subject to termination of enrollment.

____ I understand that scheduled days are established by Kiddie Campus. Tuition is not reduced for absences, family vacation time, and holiday closures or during inclement weather situations.

____ I understand that Kiddie Campus reserves the right to adjust tuition rates with at least 30 days written notice to parents.

____ I agree to pay a late pick up fee of $1.00 for every minute after 6:00pm until I arrive.

____ I understand that in the event of collection action and/or lawsuit, I will be responsible to pay all collection fees, attorney's fees, and any other cost incurred by Kiddie Campus to collect what I owe.

____ I understand that enrollment of my child is subject to a two-week trial period. After the trial period, if I am to disenroll my child, I understand that I must give a two-week notice that is paid in full.

____ I have read and understand the disenrollment policies stated in the Family Handbook. I further understand that either myself or Kiddie Campus may terminate this contract by giving a two-week notice.

If any provisions of this contract or Family Handbook are held invalid or unenforceable, it should be ineffective only to the extent of the invalidity, without effecting or impairing the enforceability of the remainder of the contract or policy.

By signing this agreement, I understand, and I will abide by the terms and conditions for attending this childcare facility.

Parent / Guardian Signature _____ Date: _____

Parent / Guardian Signature _____ Date: _____

Kiddie Campus Representative Signature _____ Date: _____

This page intentionally left blank.

Provider's Initial: ___________
Date: ___________

CHILD CARE FOOD PROGRAM
ENROLLMENT FORM

To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have question, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

Name of Day Care Facility ______________________ Telephone # ______________________

Address ______________________ City ______________________ State ______________________ Zip Code ______________________

The following information is required by USDA Federal Regulation (CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ☐ AM Snack: ☐ Lunch: ☐ PM Snack: ☐ Supper: ☐ Late Snack: ☐

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	

Please identify any food allergies or special needs your child(ren) require:

Doctor's Name: ______________________ Doctor's Telephone: ______________________

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

***OPTIONAL* Participant's ethnic and racial identities** **Please select all that apply**

Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin sex (including gender identity and sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

EMERGENCY CONTACT INFORMATION

Home Telephone #: _____ Work Telephone # _____

_____

Parent's Address City State Zip Code

Parent Signature: _____ Date: _____

*Form expires one (1) year from this date

CACFP MEAL INCOME ELIGIBILITY FORM (Child Care)

Facility Name Kiddie Campus Childcare Center **Page 1**

PART 1. NAME OF ENROLLED CHILDREN ***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of our application, and many be protected by Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes / No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐ ☐					
				☐ ☐					
				☐ ☐					
				☐ ☐					

ADDITIONAL HOUSEHOLD CHILDREN: _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD: _____**

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives benefits, skip to PART 3.**

Name	Case Number	
1. _____	_____	**NOTE: Case number is not the number found on the EBT card or an individual's Social Security number**
2. _____	_____	
3. _____	_____	

PART 3. If any child you are applying for is homeless, a migrant, or a runaway, please check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator.

☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income

***Weekly / Every 2 Weeks / Twice A Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pension, SSI, VA Benefits, Social Security Retirement	All other income	Check here if No Income
	$ _____	$ _____	$ _____	$ _____	
	$ _____	$ _____	$ _____	$ _____	
	$ _____	$ _____	$ _____	$ _____	
	$ _____	$ _____	$ _____	$ _____	

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Kiddie Campus Childcare Center **Page 2**

PART 5. Signatures and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true, and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____ (form valid for one (1) year from this date)

Address: _____ Phone number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * -__ __ __ __ (required) ☐ **I do not have a Social Security Number**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ ☐Weekly ☐Every 2 Weeks ☐Twice a Month ☐Monthly ☐Yearly Household Size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Tier I ___ Tier II ___

Reason: _____

Temporary: Free ____ Reduced _____ Time Period: _____ (expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature: _____ Date: _____

Refer to current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid'.

HNP Representative Initials/Date (for use during CACFP Reviews)
_____

The Richard B. Russell 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 the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program of Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

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 (including gender identity and sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."