

## K.I.N.D. CARE ENROLLMENT FORM

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Gender \_\_\_\_\_ Nickname \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Child's Street Address \_\_\_\_\_ PO Box \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Is mother's home address and phone same as children? Yes No

If no, please give address \_\_\_\_\_

Mother's Work \_\_\_\_\_ Work Address \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Full Name \_\_\_\_\_

Is father's home address and phone same as children? Yes No

If no, please give address \_\_\_\_\_

Father's Work \_\_\_\_\_ Work Address \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Child's Allergies & Dietary Restrictions \_\_\_\_\_

Child's Favorite Activities \_\_\_\_\_

Child's Talents: \_\_\_ Instrument \_\_\_ Dance \_\_\_ Gymnastics \_\_\_ other \_\_\_\_\_

Child's Special Needs \_\_\_\_\_

Is your child receiving daily long-term medications? Yes No

Name of medication/s \_\_\_\_\_

Will Kind care need to administer medication **during program hours**? Yes, No

If you answered yes, a **Medication Authorization Form** will need to be signed to give permission to administer medication.

Willing to participate on the Parent Board of Directors for a one year term June - May \_\_\_ Yes \_\_\_ No

**Please pick a 4 digit number** you want to use for signing in/out your child \_\_\_\_\_ mom \_\_\_\_\_ dad  
\_\_\_\_\_ other authorized person \_\_\_\_\_

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, age, disability, religion, sex, and familial status. (Not all prohibited bases apply to all programs).

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD)."

# **Parent Authorization for Emergency Medical/Dental Treatment**

(Permission for medical/dental care in parental absence)

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Known Allergies \_\_\_\_\_

Is there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while I care at the center?

Names: \_\_\_\_\_

In the event that my child may require **emergency medical, surgical care/ or emergency dental, surgical care** in the event I am unable to be reached or out of town, I hereby give my consent to medical and /or surgical treatment, dental care and /or dental surgical treatment to the following physician, hospital, dentist, or his /her designee to provide this care. I agree to pay the entire costs and fees contingent on any emergency medical/dental care and/or treatment for my child as secured or authorized under this consent.

Doctor: \_\_\_\_\_ Doctor's Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Doctors Address \_\_\_\_\_

Hospital of preference: \_\_\_\_\_ Hospital Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Dentist \_\_\_\_\_ Dentist Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Dentist Address \_\_\_\_\_

Parents/Guardians/Custodians with whom the child resides:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Work Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email Address: \_\_\_\_\_

Father's Work Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email Address: \_\_\_\_\_

## **Person(s) to be contacted in emergency if parents are unavailable:**

A. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

B. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Holder's ID. \_\_\_\_\_

This consent will be in effect beginning \_\_\_\_\_ and continue while this child is enrolled at K.I.N.D. Care.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **K.I.N.D Care Release Form**

Valid for 1 year

### **Liability**

I \_\_\_\_\_ parent/guardian of \_\_\_\_\_ will not hold KIND Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

### **Program Directory Information Release**

I Do, I Do Not, (Circle One) give permission to have the child program directors and staff print the full name of my enrolled child, the name(s) of the parent(s) with whom he/she lives, and the family's home address and phone number, in a directory which will be distributed to all of the families of children enrolled in the program.

### **Records Release Authorization**

I hereby authorize and request (name of school) \_\_\_\_\_ to release to K.I.N.D. CARE INC. a copy of the most recent immunization certificate and physical examination record of (name of child) \_\_\_\_\_ Present in their school file.

### **Picture Release**

**I Do, I Do Not** (circle one) give permission to have my child appear in any media coverage approved by K.I.N.D. CARE INC.

### **Sun Screen & Insect Repellent, Triple Antibiotic, Acetaminophen(Tylenol**

I give my permission for K.I.N.D. Care to apply or administer: (check all that apply)

\_\_\_\_\_ Apply sunscreen I have provided or provided by K.I.N.D. Care (UVB and UVA protection of SPH30 or higher), to exposed skin as needed when there is sun exposure.

\_\_\_\_\_ Apply insect repellent K.I.N.D. Care provides, (only repellants containing DEET are used) to my child's exposed skin more twice daily when there is the possible exposure to mosquitoes and other biting insects.

\_\_\_\_\_ Apply Triple Antibiotic Ointment to scraps when administering 1<sup>st</sup> Aid, according to instructions provided by manufacturer.

\_\_\_\_\_ Administer Acetaminophen (Tylenol) when body temperature exceeds 101°F or complains of headache, according to instructions provided by manufacturer.

### **Field Trips**

I Do I Do Not (circle one) give permission to have my child participate in center sponsored field trips, swimming, and off site activities.

Signature of Parent/Guardian/Custodian

Date

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## Pick-Up Authorization Form

(My child may leave K.I.N.D. CARE INC. into the following person(s) care)

Please provide a **4 digit code** for each person authorized to log your child in/out

- 
1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_ 4 digit Code \_\_\_\_\_
  2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_ 4 digit Code \_\_\_\_\_
  3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_ 4 digit Code \_\_\_\_\_
  4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_ 4 digit Code \_\_\_\_\_

Is there any **court order prohibiting** contact of your child with any person?  Yes  No, if 'Yes' **please provide a photocopy or order.**

Name of person(s) who **may not** pick up child

\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Inclement Weather Release

**If** we would have to close due to an unsafe building or weather conditions, the following person(s) has agreed to pick up my child from K.I.N.D. CARE. **The following person(s) is local and could arrive within 1 hour of notification.**

I would like staff to contact me at my employment first,  Yes,  No

Employer phone number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

**Local Contact** person authorized to pick up my child in the case of severe weather:

Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Alternate Name if this person is not available: (Optional)

Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime phone number \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Iowa School Age Care – Annual Health Status-Parent Statement

(Health statement to be completed by parent or guardian)

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Child's full name

Birth Date

1. Significant illness and or surgeries my child has had (give age at time.)

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2. Are there any special health-related needs of child (allergies, medications, injuries, etc.)

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3. Is this child subject to any conditions, which limit classroom activities or physical education?

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4. I this child subject to any condition which may result in an emergency situation

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Please ✓ in the  if statement applies to your child

**Play with friends** - My child

- Plays well in groups with other children
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children
- I am concerned about my child's play activity with other children.

**Body Health** – My child has problems with

- |  |  |
|--|--|
| <input type="checkbox"/> Skin, hair, fingernails or toenails             | <input type="checkbox"/> Mobility, uses assistive equipment              |
| <input type="checkbox"/> Stomach aches or upset stomach                  | <input type="checkbox"/> Mouth, teeth, gums, tongue, sores in mouth      |
| <input type="checkbox"/> Eyes/vision, glasses or contact lenses          | <input type="checkbox"/> Heart or heart murmur                           |
| <input type="checkbox"/> Using toilet, night time wetting                | <input type="checkbox"/> Breathing, asthma, or on lips, cough            |
| <input type="checkbox"/> Ears/hearing, hearing aides or tubes in ears    | <input type="checkbox"/> Frequent sore throats or tonsillitis            |
| <input type="checkbox"/> Constipation, diarrhea                          | <input type="checkbox"/> Nervous system, headaches, seizures, or nervous |
| <input type="checkbox"/> Nose problems, nosebleeds breaths through mouth | <input type="checkbox"/> Female monthly periods habits (like twitches)   |
| <input type="checkbox"/> Bones, muscles, pain moving                     |  |

**Medication** -My child takes medication

List meds taken at home, school, or in child care. List the name, time medication taken, and reason medication prescribed. \_\_\_\_\_

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**Allergy** – My child has the following allergies (food, medication, latex, inhalants, insects, animals, etc.):

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Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**K.I.N.D. CARE  
SUMMER CARE AGREEMENT 2011**

**Dates/Hours**

Kind Care Summer Program will be open, M-F 6:00Am - 6:00Pm June 1 through August 16, 2011. We will be closed **Mon. July 4th**

**Attendance** I will notify KIND Care staff as early as possible when my child will not be participating or arriving late. I, or a designated adult, will bring and pick up my child at the scheduled their time. All legal parent/guardians will be allowed to pick up their child/ren unless there is a legal document on file at Kind Care stating otherwise. I will not permit my child to participate in Kind Care if he/she is sick. If my child becomes ill at the Program, I will arrange transportation for him/her to return home. If a medical emergency arises, the Program staff will first attempt to contact me, if I cannot be reached, or my established emergency people cannot be reached, the staff will contact my child's doctor. If necessary, an ambulance or emergency vehicle may take my child to the hospital.

**Absences** If my child is absent, I will be responsible for payment for the days or weeks my child is contracted. I will give a courtesy call to let a staff know if my child will be absent on any scheduled day. (Part-time status will need to give a 24-hr notice of absence before his/her scheduled day, as a no-call no-show will result in a charge for the missed scheduled day).

**Drop Program Notice** If for any reason I need to drop the program, I agree to give a **pre-paid written 2-week notice.**

**Meals** Kind Care will provide breakfast, milk at lunch, and pm snack that will follow the **CACFP standards**. I agree to send my child a sack lunch that is nutritionally sound on all sack lunch days. My child has the option on Thursdays, to bring \$3.00 to order pizza for lunch.

Sack lunches will have four main rules:

- 1) No trading of food will be allowed
- 2) No pop/soda will be allowed
- 3) No large candy will be allowed
- 4) Use a cool pack if lunch requires cooling

**Discipline:** I understand that the KIND Care reserves the right to limit participation of my child for disciplinary reasons as stated in the parent handbook

**Fee Policy** Weekly fees are due in advance on Mondays or the first day of my child's scheduled week. Fees not paid by Wed. 6:00AM, a late charge of \$10.00 will be added in the PM of Wed. I am responsible for payment for the days and weeks contracted for my **child**.

**If my child is absent on a scheduled day I will be** responsible for full payment of that day or week.

My child's start date will be \_\_\_/\_\_\_/2010      Arrival time \_\_\_\_\_ depart time \_\_\_\_\_

**Fulltime**

Definition: Contract **8 or more** full weeks

Full weeks = 4-5 days

\_\_\_\$122.00 pr wk pr child, contract (8-11 wks)

\_\_\_\$116.00 pr wk for one child (fundraise option discount)

**½ Days**

Definition: Contract a 1/2 day. Two shift choices any hrs between 6am-12:30pm or 12:30-6pm.

\_\_\_\$20.00 pr ½ day shift pr child

**Partial Fulltime**

Definition: Contract **fewer** than 8 full wks

\_\_\_\$130.00 pr wk pr child, contract (5-7 wks)

\_\_\_\$124.00 pr wk one child (fundraise option discount)

\_\_\_\$140.00 pr wk pr child, contract (1-4 wks)

\_\_\_\$134.00 pr wk one child (fundraise option discount)

**With a 24 hour notice I may convert my ½ day to the full day drop-in rate**

½ day 10-minute grace period:

Am Pickup 12:40

Pm Drop off 12:20

**I will be charge an additional full ½ day charge if I go beyond the 10-minute grace period at drop-off or pick-up.**

\_\_\_\_\_ Please initial

**Daily Drop-in**

Definition: Contract by the day

\_\_\_\$32.00 pr day pr child

**A fundraising option discount:**

Receive a \$6.00 discount **each week** for each child by participating in our Birdies for Charity event. It is simple and requires very little effort or time **Four, one-penny pledge for each child** turned in by June 1st will qualify you for your discount. Failure to participate in fundraising I forfeit my discount and my account will be charged an additional \$6.00 per week of attendance per child. **In the event that any of the pledges I turn in are not paid my account may be charge for the difference.**

**Registration/Activity Fees: Full-Time & Partial Fulltime:**

Registration Fee - \$50.00 (**non refundable**) late reg. \$15.00 after the deadline

Activity Fee - \$60.00 (**refundable through May 14, 2011**) no exceptions.

**Drop-In plus, ½ Days and any Partial Full-Time 4 wks and under**

Registration Fee \$50.00 (**nonrefundable**) late reg. \$15.00 after the deadline (May 2)

Activity Fee \$30.00 (**refundable through May 13, 2011**) no exceptions (**Fieldtrips are an additional \$10.00 pr trip**)

I agree to pay **in advance** the following contracted weeks (check one) \_\_\_ Wkly \_\_\_ Bi-Wkly \_\_\_ Monthly.

**Contracted weeks will be as follows:** *Check all that apply*

\_\_\_ **Week 1** June 1-3 (3 days)

\_\_\_ **Week 4** June 20-24

\_\_\_ **Week 7** July 11-15

\_\_\_ **Week 10** August 01-05

\_\_\_ **Week 2** June 6-10

\_\_\_ **Week 5** June 27-July 1

\_\_\_ **Week 8** July 18-22

\_\_\_ **Week 11** August 08-12

\_\_\_ **Week 3** June 13-17

\_\_\_ **Week 6** July 4-8

\_\_\_ **Week 9** July 25-29

\_\_\_ **Week 12** August 15-16 (2 days)

**Consent/Liability**

I give my consent for (child's name) \_\_\_\_\_ to participate fully in the Kind Care Summer Program 2011

I will not hold Kind Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

|  |
|--|
| <b>Iowa Child and Adult Care Food Program Enrollment Information</b> |
| <b>K.I.N.D Care Inc</b>  |

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

|  |  |  |   |   |                                       |
|--|--|--|---|---|---------------------------------------|
| <b>Indicate</b>  |  |  |   |   |                                       |
| <b>1. Ethnic</b>   |  |  |   |   |                                       |
| <b>2. Racial Identity</b>  |  |  |   |   |                                       |
| <b>Of the enrolled child with a check mark in the appropriate box below. Answering these questions is voluntary.</b> |  |  |   |   |                                       |
| <b>1. Ethnic Identity of Child</b>   | Hispanic or Latino<br><br><input type="checkbox"/>               | Non Hispanic or Latino<br><br><input type="checkbox"/> |   |   |                                       |
| <b>2. Racial Identity of Child</b>   | American Indian or Alaska Native<br><br><input type="checkbox"/> | Asian<br><br><input type="checkbox"/>                  | Black or African American<br><br><input type="checkbox"/> | Native Hawaiian or Other Pacific Islander<br><br><input type="checkbox"/> | White<br><br><input type="checkbox"/> |

**School Year:**

My Child's usual time of attendance will be: Circle

Days: Monday    Tuesday    Wednesday    Thursday    Friday    Drop-in only

Hours Am: Arriving at \_\_\_\_\_ Departing at \_\_\_\_\_

Hours Pm: Arriving at \_\_\_\_\_ Departing at \_\_\_\_\_

**Summer Program**

My Child's **usual time** of attendance will be: Circle

Days: Monday    Tuesday    Wednesday    Thursday    Friday    Drop-in only

Hours: Arriving at \_\_\_\_\_ Departing at \_\_\_\_\_

**My child's anticipated meal participation will be:**

- Breakfast                       Am Snack                       Lunch                       Pm Snack

Signature \_\_\_\_\_ Date \_\_\_\_\_