

School Age Registration Packet

We are honored that you chose to enroll your child in Great Plays. We are excited to serve you and strive to provide a fun, enriching and stimulating early learning experience for your child. Before we consider your registration complete, we will need the items listed below to register your child. Most of these forms can be found in this Registration Packet. ALL line items must be completed. An incomplete registration packet may result in you forfeiting your classroom spot.

- _____ Signed School Release Form
- _____ Emergency Contact & Medical Information Form (completed)
- _____ Family & Social History form (completed)
- _____ Non-refundable Registration Fee

On or before the first day of school, the following must be provided in order for your child to attend:

- _____ A Health Status – Parent Statement Form. This form is included in the Registration Packet and can be completed by the child’s parents.
- _____ Current immunization Record.

Please indicate with an X the times your child will typically be attending Great Plays Extended Day Program:

- Monday: _____ AM _____ PM
- Tuesday: _____ AM _____ PM
- Wednesday: _____ AM _____ PM
- Thursday: _____ AM _____ PM
- Friday: _____ AM _____ PM

_____ We are currently looking for care on an *as needed* basis, and won’t have a typical schedule

SCHOOL RELEASE FORM

Great Plays Extended Day students may be photographed or videotaped, and their name and/or work displayed for educational and/or not-for-profit use in various ways; newspaper articles, school newsletters, building videos, school website, etc. If you do NOT want your child to participate in the above activities you must submit your request in writing to the Program Director by the first day your child attends the center.

Child's Full Name _____ Date _____

SUNSCREEN APPLICATION RELEASE & POLICY

Children at Great Plays Daycare will often be outside at peak sunlight hours. With specified permissions, and upon providing an individual sunscreen product, the staff will apply sunscreen to your child. Sunscreen will only be applied to exposed areas of the body, including the face, tops of ears, nose, bare shoulders, arms and legs. I have read the options below and marked my preference.

_____ I do NOT wish to have sunscreen applied to my child while at Great Plays Daycare.

_____ I give permission to Great Plays Daycare to apply sunscreen to my child with the product that I have/will provide at regular intervals.

INSECT REPELLANT APPLICATION RELEASE & POLICY

Children at Great Plays Daycare will often be outside, and in contact with insects that may bite. With specified permissions, and upon providing an individual insect repellent product, the staff will apply insect repellent to exposed areas of your child's body, including the face, tops of ears, nose, bare shoulders, arms and legs. I have reviewed the options below and marked my preference.

_____ I do NOT wish to have insect repellent applied to my child while at Great Plays Daycare.

_____ I give permission to Great Plays Daycare to apply insect repellent to my child with the product that I have/will provide at regular intervals.

Parent's Signature _____ Date _____

Staff Initials _____

-----Office Use Only-----

- () Emergency Medical Form
- () Physical Examination
- () Current Immunization Record
- () Family/Social Information Sheet
- () Non-Refundable Registration Fee

IOWA SCHOOL AGE CARE
HEALTH STATUS – PARENT STATEMENT

Parent/Guardian complete this page

Please check the box next to the statement that applies to your child.

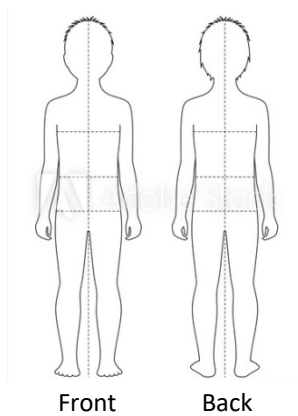
Date of child's last physical exam _____

Date of last dental appointment _____

- _ I am concerned about my child's growth.
- _ I am concerned about my child's eating habits.

_ My child needs rest after school.
_ My child had/has a serious illness, surgery, or injury.
Please describe: _____

_ My child must restrict physical activity or needs special equipment to be active.
Please describe: _____



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-
- 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.
 - Is doing well at school.
 - Is having difficulty in some classes.
 - Does not want to go to school.
 - Frequently misses or is late to school.
 - I am concerned about how my child is doing in school.

Please describe: _____

My child has allergies:
 List all allergies: (food, medicine, inhalents, insects, animals, etc...) _____

Child has Epipen, Inhaler, or other Emergency Medication
 Yes No

Parent/Guardian's Signature	Date
Child's Name:	

Body Health – My child has problems with:
 Skin, Hair, Fingernails or toenails.
Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below:

- Eyes/Vision, glasses or contact lenses
 - Ears/hearing, hearing assistive aids or device, earache, tubes in ears.
 - Nose problems, nose bleeds
 - Mouth, teeth, gums, tongue, sores in mouth or on lips, breathes through mouth
 - Frequent sore throat or tonsillitis.
 - Breathing problems, asthma, cough.
 - Heart problems, heart murmur.
 - Stomach aches or upset stomach.
 - Trouble using toilet or wetting accidents.
 - Hard stools, constipation, diarrhea, watery stools.
 - Bones, muscles, movement, pain when moving
 - Mobility, child uses assistive equipment.
- please describe: _____

- Nervous system, headaches, seizures, or nervous habits (ex: twitches or ticks)
 - Females – difficult monthly periods.
 - Other special needs. Please describe: _____

- My child takes medication
- | | | |
|-----------------|------------|-------------------|
| | | |
| Medication Name | Time Given | Reason for giving |

Family & Social History Form

Child's Full Name: _____ DOB: _____

In order to help the teachers to know a little bit about your child, please take a few minutes to complete this Family & Social History form and return it with your Registration Packet.

Does your child have any Food/Environmental/Medicine Allergies YES UNKNOWN

If yes, please list: _____

*If an allergy is identified, we will be contacting you shortly to request a health plan. This health plan is in place so that all the staff know the proper actions to take if your child comes in contact with their allergen. We must have a health plan in place for all allergies except medication allergies.

Does your child have a nickname? _____

Parent's marital status married single divorced widowed re-married partner

Who does the child live with Mom Dad Both Grandparents Other

Primary language spoken in the home: _____ Secondary: _____

Child's Ethnicity: _____

Does your child currently nap or rest during the day? YES No If yes, how long? _____

Does your child use the restroom independently? YES No
(not a program requirement)

Does your child experience any toileting difficulties? YES No

If yes, please explain: _____

Does your child wear a pull-up? Day Night Diapers

What type of toys does your child enjoy playing with?

Has your child been in another preschool, daycare or play group? YES No Group size? _____

Describe your child's previous group care experience: _____

Does he/she accept new people/activities easily? YES No

If no, please explain: _____

What are your child's fears? _____

What does your child especially enjoy? _____

Has your child experienced any of the following:

Asthma/Wheezing

Heart Disorder

Kidney/Bladder

- Scarlet Fever
- Mumps
- Chicken Pox
- Other

If yes to any of the above, please elaborate on each condition: _____

Has your child experienced any of the following:

- Nose Bleeding
- Seizures
- Fainting
- Medications
- Eczema/Dry Skin
- Other

If yes to any of the above, please elaborate on each condition: _____

Please list any siblings name's and their ages below:

What do you hope for your child to gain from our program(s) this year at Great Plays?

Please give any further information which you believe will be helpful to best understand how we can partner together in caring for your child (topics to include may be temperament, toileting, sleeping, eating, family, etc.):

Parent Signature: _____ Date: _____

**GREAT PLAYS
EMERGENCY CONTACT AND MEDICAL INFORMATION FORM**

Child's Name

_____ **M F**
Date of Birth Sex

Parent/Guardian's Name

Parent/Guardian's Name

Primary Phone

Work Phone

Primary Phone

Work Phone

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Employer

Employer

Daytime Contact 1 (Name & Number)

Daytime Contact 2 (Name & Number)

Primary Email Address *Billing Statements and
correspondence will be sent to this address

Secondary Email Address

**Alternative Emergency Contacts
(in addition to parents)**

Primary Emergency Contact

Secondary Emergency Contact

Primary Phone

Work Phone

Primary Phone

Work Phone

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

MEDICAL INFORMATION

Hospital/Clinic Preference

Physician's Name

Phone Number

Physician's Address

Date of Last Visit

Insurance Company

Policy Number

Dentist's Name

Phone number

Dentist's Address

Date of Last Visit

Insurance Company

Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-Ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waived my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of emergency.

Parent's/Guardian's Signature

Date

I give permission for my child to go on field trips. I release Great Plays and individuals from liability in case of accident during activities related to Great Plays as long as normal safety procedures have been taken.

Parent's/Guardian's Signature

Date

Staff Signature

Date

Pick-Up Permission List

Child's Full Name: _____

I, _____, hereby give permission for my child to leave Great Plays with the following persons named below.

NAME	CONTACT NUMBER	RELATIONSHIP

I understand that it is my responsibility to notify Great Plays of any changes to this form.

Parent's/Guardian's Signature

Date

Staff Signature

Date



Your child is enrolled in a center that participates in the Child and Adult Care Food program (CACFP). By participating in this program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

Iowa Child Adult Care Food Program

Child Care Enrollment Form

Times of Care	Regular Days of Care	Meals Served During Care	Ethnicity/Race
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Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	TH	F	S	S	B	AM SN	Lu	PM SN	D	E SN	Ethnicity	Race	

*Ethnicity (Select one and enter in the chart above): H= Hispanic or Latino or N= Not Hispanic of Latino

*Race (Select one of more and enter in the chart above): W= White, B= Black or African American, I= American Indian or Alaska Native, A= Asian, and P= Native Hawaiian or Other Pacific Islander. This information is requested by the Federal Government in order to monitor compliance with Civil Rights Laws. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center’s Program representative is required to note on the basis of visual observation.

Infants Only (0 to 12 months): I am not enrolling an infant (skip this section)

As a participant in the USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

I will provide breastmilk for my infant. Yes No Centers formula may be used to supplement feeding if necessary Yes No

I would like to breastfeed onsite, if the option available¹ Yes No

Yes, time(s) _____

I will provide formula for my infant. Name of formula (must be iron-fortified formula and manufactured in the USA): _____

I accept the center's formula for my infant. Name of iron-fortified formula: _____

I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

I will provide solid foods for my infant². The center may supplement with additional solid foods when my infant needs them

Yes No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

¹Ask your center if you can breastfeed on site.

²The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal