



Enrollment Form

Child's Name _____

Birthdate _____

Projected start date _____

Child's Primary Home Address _____

Parent(s) or Guardian(s)

Name _____

Home Address (if different than child's): _____

Home Phone _____

Work Phone _____ Cell Phone _____

Occupation & Place of Work _____

E-mail _____

Name _____

Home Address (if different than child's): _____

Home Phone _____

Work Phone _____ Cell Phone _____

Occupation & Place of Work _____

E-mail _____

Child lives with: Mother _____ Father _____ Both _____ Other (Please Specify) _____

Both parents/guardians are assumed as authorized to pick up the child and to be contacted by the program as needed and unless we have a court order on file specifying otherwise.

Emergency Contacts

Please provide a **minimum of two** emergency contacts other than the parents who are authorized to pick up your child (no maximum). Contacts **must** include legal name, full address, and at least one phone number.

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____



Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Doctor's Name _____ Phone _____

Address _____

Dentist's Name _____ Phone _____

Address _____

Optional:

Health Insurance Provider: _____

Policy and Group Number: _____

Please initial your child's days of attendance. Part time schedules must include Monday and/or Friday.

M

T

W

TH

F

Child's typical daily schedule of attendance will be from _____ am/pm to _____ am/pm

Please describe anything you would like our staff to know about your child's eating, sleeping, toileting, communication, and comforting habits and methods.

Please describe any dietary and/or medical needs or specifications.

If applicable, please provide documentation of any Individual Child Care Program Plan (ICCPP) needs.

We must receive a completed Health Care Summary and Immunization Record signed by your child's health care provider prior to admission to our program. You are required to submit additional medical information at least annually and/or whenever your child advances into an older age category.

Parent/Guardian Signature _____ Date _____

Office use:

- G
 V
 C/MB
 K
 B
 H/I
 MIIC
 PL/ A
 SC
 N/DA
 NB-For Infants Only
 F/C



Parent Contract

1. I have read, understood and agree to all policies in the Parent Handbook and all enclosed information including hard and digital copies that I received at enrollment including but not limited to enrollment and tuition terms, and termination of care. I understand that the Parent Handbook may be updated on at least an annual basis, and I hereby agree to be bound by any such updates to the Parent Handbook.
 Termination of Care
 Holidays and Vacations, Parent Conferences, Right to Close, Care of Ill Children, Vacations and, Severe Weather
 Privacy Policy
 Staff Boundary Policy
 Addendum-Closure Policy on a Pandemic Emergency

2. I authorize the staff of TenderCare Learning Center to use the following products/non-prescription medications on my child. These products will be used according to the manufacturer's instructions and as staff deem necessary or appropriate. Please notify us in writing if this is not okay with you.
 - o Cloth diapers and wipes
 - o Soap
 - o Diaper Rash Cream, and Sunscreen (provided by parents/guardians)

3. First Aid Supplies

4. I authorize the staff of TenderCare Learning Center to administer First Aid and CPR if necessary, to seek professional medical care in the case of an emergency, and to have access to health/medical information about my child.
5. Subject to the terms of the Parent Handbook (as amended from time to time), I give permission for my child to walk to and/or participate in activities geared for my child away from the child care center under the supervision of TenderCare Learning Center staff.
6. Consistent with the terms of the Parent Handbook (see "—Privacy Policy"), I authorize TenderCare Learning Center to capture, use, copyright or publish photographs, videotapes, motion pictures, recordings, or any other media images taken of my child, or in which my child appears, without restrictions or compensation of any kind. I authorize photos, videotapes, motion pictures, recordings, or any other media images of my child for use within the TenderCare Learning Center and agree that group photos in which my child appears may be shared with other enrolled families. I also agree to release TenderCare Learning Center from all liability or claims arising out of its use of such photographs, videotapes, motion pictures, recordings, or any other media images.
7. The Parent Contract, together with the Parent Handbook (as amended from time to time), constitutes the entire agreement regarding the provision of childcare services by TenderCare Learning Center. No waiver of any provision of this Parent Contract (including the Parent Handbook, as amended from time to time) by TenderCare Learning Center on any one occasion shall constitute a waiver of any other provision, nor shall it constitute a waiver of such provision on any later occasion.
8. I have been provided the emergency plan and I have also been informed that is made available upon request.

Child's Name _____
Parent Signature _____ Phone _____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name _____ Birthdate _____

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B	<input type="text"/>	<input type="text"/>			
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)		<input type="text"/>		<input type="text"/>	<input type="text"/>
Chickenpox (varicella)		<input type="text"/>		<input type="text"/>	<input type="text"/>
Hepatitis A		<input type="text"/>	<input type="text"/>		
Tetanus, Diphtheria, Pertussis (Tdap)				<input type="text"/>	
Meningococcal (MCV4)				<input type="text"/>	<input type="text"/>

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date) by _____ (name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____

Birth Date _____

ADDRESS _____

Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's . . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program _____

Phone _____

Signature of Health Source _____ Address _____

Date _____