

**Immanuel Lutheran Child Care**  
**Days and Hours Needed For Child Care**

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Anticipated First Day Of Attendance:** \_\_\_\_\_

**Monday** \_\_\_\_\_

**Tuesday** \_\_\_\_\_

**Wednesday** \_\_\_\_\_

**Thursday** \_\_\_\_\_

**Friday** \_\_\_\_\_

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

**CHILD CARE ENROLLMENT**

**Use of form:** Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(4)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

**CHILD INFORMATION**

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance
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**PARENT OR GUARDIAN** – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)

Does child reside at this location?	Place of Employment and Work Phone No.
<input type="checkbox"/> Yes <input type="checkbox"/> No	

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)

Does child reside at this location?	Place of Employment and Work Phone No.
<input type="checkbox"/> Yes <input type="checkbox"/> No	

**AUTHORIZED PERSONS** – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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**EMERGENCY CONTACT** – The person to be notified in an emergency when parents / guardians cannot be reached.

<input type="checkbox"/> Yes <input type="checkbox"/> No This person is authorized to pick up the child.	Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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**PHYSICIAN OR MEDICAL FACILITY**

Name	Address (Street, City, State, Zip Code)	Telephone Number
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**AUTHORIZATIONS**

Yes  No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.  
 Yes  No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.  
 Yes  No I give permission for my child to participate in  Transported  Walking field trips and other activities during operating hours.  
 Yes  No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

**SIGNATURE** – Parent or Guardian

Date Signed

**IMMANUEL LUTHERAN CHILD CARE CHILD INFORMATION SHEET**

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Fathers' Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

E-mail Address (Father): \_\_\_\_\_ (Mother): \_\_\_\_\_

Names of those with permission to pick up your child(ren):  
\_\_\_\_\_  
\_\_\_\_\_

In case of emergency, which parent/phone number should we try first? \_\_\_\_\_

Who is responsible for payment: \_\_\_\_\_ Religious Affiliation: \_\_\_\_\_

Church Home: \_\_\_\_\_ Baptismal Date: \_\_\_\_\_

Siblings and ages: \_\_\_\_\_

Is there anything else about your child that would be helpful for us to know?  
\_\_\_\_\_  
\_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

How did you hear about Immanuel Lutheran Child Care?  
\_\_\_\_\_  
\_\_\_\_\_

**I give permission for my child's photograph and/or video images to be taken during activities held by Immanuel Lutheran Child Care and used for promotional/informational use in regards to Immanuel Lutheran Child Care:**

\_\_\_\_\_  
(parent signature)

**HEALTH HISTORY AND EMERGENCY CARE PLAN**

**Use of form:** This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

**CHILD INFORMATION**

Name (Last, First, MI)		Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)	

**PARENT / GUARDIAN INFORMATION** Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

Name – Physician	Address – Medical Facility	Telephone Number
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**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply repellent.		

**HEALTH HISTORY AND EMERGENCY CARE PLAN** If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

- No specific medical condition
- Asthma
- Cerebral palsy / motor disorder
- Other condition(s) requiring special care – Specify.
- Diabetes
- Epilepsy / seizure disorder
- Gastrointestinal or feeding concerns including special diet and supplements
- Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

Food allergies – Specify food(s).

Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

**SIGNATURE** – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates:

## DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

### PERSONAL DATA

PLEASE PRINT

<b>STEP 1</b>	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

### IMMUNIZATION HISTORY

**STEP 2** List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

**Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.**  
 Yes year \_\_\_\_\_ (Vaccine is not required)  
 No or Unsure (Vaccine is required)

### REQUIREMENTS

**STEP 3** The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	2 Hep B	1 MMR <sup>3</sup>
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	3 Hep B	1 MMR <sup>3</sup> 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT <sup>4</sup>	4 Polio			3 Hep B	2 MMR <sup>3</sup> 2 Varicella

<sup>1</sup>If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).  
<sup>2</sup>If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.  
<sup>3</sup>MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1<sup>st</sup> birthday is also acceptable).  
<sup>4</sup>Children entering kindergarten must have received one dose after the 4<sup>th</sup> birthday (either the 3<sup>rd</sup>, 4<sup>th</sup> or 5<sup>th</sup>) to be compliant (Note: a dose 4 days or less before the 4<sup>th</sup> birthday is also acceptable).

### COMPLIANCE DATA AND WAIVERS

**STEP 4** IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR  
 IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

**NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.**

For health reasons this child should not receive the following immunizations \_\_\_\_\_ (List in STEP 2 any immunizations already received)

\_\_\_\_\_  
 Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

### SIGNATURE

**STEP 5** To the best of my knowledge this form is complete and accurate.

\_\_\_\_\_  
 SIGNATURE - Parent, Guardian or Legal Custodian

\_\_\_\_\_  
 Date Signed

### CHILD HEALTH REPORT – CHILD CARE CENTERS

**Use of form:** Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

**PARENT OR GUARDIAN – Complete this section.**

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)
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Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

**HEALTH PROFESSIONAL – Complete this section.**

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

Yes  No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: \_\_\_\_\_ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

**AUTHORIZATION**

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)
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SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination
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## **Immanuel Lutheran Child Care Parental Agreement**

Please initial each statement and sign the bottom to indicate you have read the parent handbook and understand your responsibilities as a parent with a child(ren) at Immanuel Lutheran Child Care.

\_\_\_\_\_ I agree to comply with the rules and regulations of Immanuel Lutheran Child Care and Church regarding fees and payments.

\_\_\_\_\_ I understand that child care fees are to be paid weekly for the anticipated/scheduled time my child is in Child Care. I agree to pay the annual registration fee in addition to my weekly fees.

\_\_\_\_\_ I have read the policy regarding advance notice of absences or extra child care needs and realize I may be charged for not giving proper notification.

\_\_\_\_\_ I understand that Immanuel Lutheran Child Care does not accept sick children and I am aware of the guidelines presented in the handbook.

\_\_\_\_\_ I am responsible for updating my child's emergency information as needed.

I understand my responsibilities as laid out in the parent handbook and in the preceding statements.

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

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

Date \_\_\_\_\_

Signature of Child Care Director \_\_\_\_\_

Revised 4/2007

## INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under age 2 in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** This form is to be completed by a parent and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

### PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)

Nickname (If any)

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

**HEALTH** Note: Health conditions that may affect the care of the child must be recorded on the department's form, Health History and Emergency Care Plan. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

### UPDATES

### MEALS

Current feeding schedule

Length of time on current schedule

Food type

Formula  Strained  Junior  Table  Milk type – Specify:

New food timetable

When eating, child is –

Held in lap  In highchair  Other – Specify:

Feeds self

Yes  No If "Yes", uses:  Spoon  Fork  Hands

Special feeding problems

Yes  No If "Yes" – Specify:

Food allergies

Yes  No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

### UPDATES

**SLEEP**

Current sleep schedule

Length of time on current schedule

Falls asleep easily

 Yes  No

Mood upon awakening – Describe.

Takes favorite toy(s) to bed – **child over age 1 year** Yes  No If "Yes" – list toy(s):Sleep position – **child under age 1 year****Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. Back for children under age 1 year  Side or stomach (physician statement attached)Sleep position – **child over age 1 year** Back  Side or stomach

UPDATES

**DIAPERING / TOILETING**

Diaper – type

 Cloth  Disposable

Diapers provided by parent

 Yes  No

Plastic pants used

 Always  Never  Sometimes If "Sometimes" – Specify:

Highly sensitive skin

 Yes  No

Frequent diaper rash

 Yes  No

Lotions, powders or salves used

 Yes  No If "Yes", product name(s) – Specify:

Toilet training attempted

 Yes  No If "Yes", describe routine.

Type of toilet seat used at home

 Potty chair  Special toilet seat  Regular toilet seat

Regular bowel movements

 Yes  No How often.

Time(s) of day:

Toileting problems

 Yes  No If "Yes" – Describe.

UPDATES

**VERBAL COMMUNICATION**

Family speaks what language – Specify.

 English  Other If "Other" – Specify:

Age child began talking

Child speaks in

 Words  Sentences

Words used to describe special needs – Specify.

UPDATES

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**COMFORTING**

Does child have a fussy time?

Yes  No If "Yes" – Specify time.

How is fussy time handled?

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Child likes to be:

Held  Sung to  Rocked  Read to  Other – Specify:

Special things you say or do to comfort child.

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UPDATES

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**SELF-EXPRESSION**

What causes your child to feel angry or frustrated?

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What frightens your child and how is it shown?

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How does your child express feelings of happiness, enjoyment, etc.?

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Additional comments

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UPDATES

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**PHYSICAL AND SOCIAL DEVELOPMENT**

Is your child able to – (Check all that apply)

Sit up alone  Pull up  Crawl  Walk holding on  Walk without support

Yes  No Is your child used to playmates?

Comments

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UPDATES

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**MISCELLANEOUS**

Child's **indoor** favorite toys and activities – Specify.

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Child's **outdoor** favorite toys and activities – Specify.

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By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

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**UPDATES**

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**SIGNATURE** – Parent or Guardian

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**Date Signed**