Lac qui Parle Valley Community Education & Recreation
Littlest Eagles Daycare Contract 2018-19

First date contract begins _____ ☐ Infant Care & Early Education (6 weeks – 11 months)

Child's Name _____

Parent/Guardian(s) Names _____

Billing/Home Address _____

Primary Contact's Cell Phone _____

All-Day Child Care

Hours: 5:45 A.M. – 6:00 P.M.
Meals Included: Breakfast, Lunch, and Afternoon Snack
Please see Parent Handbook for more information on meals

Other fees I may be charged:

- A non-refundable registration/waitlist fee of $25.00 per child
- A $25.00 charge for any checks returned for non-sufficient funds
- A $10.00 late fee for any payments not paid before the next billing cycle.
- A late fee of $5.00 for every 5 minutes past 6:00PM.
- Certain Classroom enrichment activities offered through outside vendors.

Rates

5-Day: $175.00/Week

4-Day: $145.00/Week

3-Day: $110.00/Week

Drop-In: $40.00/Day
(Only if spot is available, please call no more than 24 hours ahead of time)

	Estimated Drop-Off Time	Estimated Pick-Up Time
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

Little Eagles Care observes the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day. If the holiday falls on a Saturday, the programs will be closed on the preceding Friday. If the holiday falls on a Sunday, the programs will be closed on the following Monday. You are billed for these holidays if the "observed" holiday falls on a day that you are normally contracted.

I agree with the specified terms of this contract and I understand this contract that I am signing. I understand that I will be charged the weekly contracted rate for the days I contracted for. Any days in addition to my contracted days will result in a drop-in charge. I understand that withdrawal or changes to this contract require a **two-week written notice**. I am aware that I will pay a two-week notice to withdraw from/make changes to this contract, whether my child attends those two weeks or not.

Unless withdrawn or age eligible to transition to a different group, this contract is valid from the start of enrollment until 1/1/2020.

Signature _____ Date _____

Little Eagles Daycare

Child's Registration Record

Child Information

Full Name: _____ Birthdate: _____

Address: _____ Phone: _____

Parent or Guardian #1

Name: _____

Address: _____

Phone: (h) _____ (c) _____ Email:

Place of work: _____ Phone: _____

Parent or Guardian #2

Name: _____

Address: _____

Phone: (h) _____ (c) _____ Email:

Place of work: _____ Phone: _____

Emergency Contacts (who may be contacted in case parents cannot be reached)

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Medical and Dental Information

Physician Name: _____ Phone: _____

Health Care Facility Name: _____

Health Care Facility Address: _____

Health Concerns: _____

_____

_____

Dentist Name: _____ Phone: _____

Dentist Facility Name: _____

Dentist Address: _____

Pick Up Authorization

The following have permission to pick up my child from Little Eagles Daycare:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

The following are unauthorized and CANNOT pick up my child (documentation required)

Name: _____ Name: _____

Permissions

_____ I give my permission to Little Eagles Daycare staff to provide appropriate care for my child in an emergency, in the event I cannot be reached or am delayed.

_____ I have completed the Permission to Administer Prescription and Non-Prescription Medications Form.

_____ I understand that I must complete a Health Care Summary for my child **within 30 days of enrollment** and an immunization record must be provided **at the time of enrollment**.

_____ I give my permission for my child to be photographed for center curriculum, projects and newspaper articles.

_____ Your child will be participating in an assessment tool. This is a non-standardized assessment that measures development progress in children birth through Kindergarten and is part of our preschool curriculum. Parents will receive copies of this information during parent conferences. I give my child permission to participate.

_____ I have been offered the Little Eagles Daycare Program Policies, have been offered a tour of the facility and have been made aware of the conference scheduled days.

Parents of infants are also required to review and complete Safe Sleep Documentation which will be included in the registration information received from Little Eagles Daycare.

I authorize Little Eagles Daycare to care for my child. I will keep Little Eagles Daycare current on all relevant information regarding my child. I will read and abide by the policies outlined in the Parent Handbook and the terms of this agreement.

_____ _____

Signature Date

Little Eagles Daycare

Health Care Summary and Immunization Forms

The following two documents must be completed in full and returned to Little Eagles Daycare prior to your child starting with the program.

These forms are supplied by the Minnesota Department of Human Services and are required.

The Health Care Summary must be filled out and signed by your child's physician **within 30 days of enrollment**; we are not allowed to accept forms generated by a medical center.

The Child Care Immunization Form is a two page document; be sure to complete both sides, and turn in **at the time of enrollment**.

Page 1: you may use the print out received from your clinic to complete this page. No signature necessary.

Page 2: A signature is *required* in one of the four boxes. Please read each box to see which one best fits the age and immunization history of your child.

*If you are choosing Box 2A (medical exemption) a physician must sign and date.

*If you are choosing box 2B (conscientious exemption) you must have your signature notarized.

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

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

MS-2083

Child Care Immunization Form

*Must be on file **before** a child attends child care*

Name _____ Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in child care to be immunized against certain diseases or file a legal medical or conscientious exemption.

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

Type of Vaccine DO NOT USE (✓) or (✱)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year *(at 2-month intervals)* • 4th dose at 12-18 months • 5th dose at 4-6 years *Indicate vaccine type: DTaP or DTP*					
Polio (IPV, OPV) • 2 doses in the first year • 3rd dose by 18 months • 4th dose at 4-6 years					
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
***Haemophilus influenzae* type b (Hib)** • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older					
Varicella (chickenpox) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2 - 24 months • 3 doses in the first year • 4th dose after 12 months • At least 1 dose is recommended for children 24-59 months in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older					
Recommended					
Rotavirus (2-3 doses between 2 and 6 months)					
Influenza (annually for children 6 months or older)					

5th dose not required if 4th dose was given on or after the 4th birthday

4th dose not required if 3rd dose was given on or after the 4th birthday

Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:

For children who are 15 months or older and who have received all the immunizations required by law for child care:

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

_____
Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

B. Children who are younger than 15 months:

For children who are younger than 15 months OR have not received all required immunizations:

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:

No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician / nurse practitioner / physician assistant

_____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

_____
Signature of physician / nurse practitioner / physician assistant (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:

No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____
Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20____

_____
Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

Little Eagles Daycare

Permission to Administer Prescription & Non-Prescription Medications

Childs Name:_____ **Birthdate:**_____

Please check all that apply:

☐ Diaper Wipes	☐ Baby Powder	☐ Acetaminophen
☐ Diaper Ointment	☐ Baby Oil	☐ Adhesive Tape
☐ Numbs It	☐ Baby Lotion	☐ Band-Aids
☐ Vaseline	☐ Lip Balm	☐ Burn Ointments
☐ Cough Syrup	☐ Bar Soap	☐ Rash Ointments
☐ Antiseptic Wipes	☐ Toothpaste	☐ Antibiotic Ointments
☐ Itching Creams	☐ Shampoo	☐ Hand Lotion
☐ Mentholatum Rubs	☐ Sunscreen	☐ Other:_____
☐ Hydrogen Peroxide	☐ Insect Repellant	☐ Other:_____
☐ Other:_____	☐ Other:_____	☐ Other:_____

RX from Doctor:

Parent's Initials	RX Name and No.	Date	Length of Prescription	Time and Amount to be administered
ABC	*Amoxicillin/Rx 043251*	*1/23/45*	*10 days – 3x per day*	*7am/2pm/9pm 1 teaspoon*

I give my permission for Little Eagles Daycare to administer the above products and prescriptions according to my doctor or manufacturer's instructions unless otherwise specified.

Parent's Signature: _____

_____

Date: _____

Little Eagles Daycare

Child's Name *Date of Birth*

My Sleeping Habits:

Diapering/Toileting Habits/Preferences:

My eating schedule:

My special food likes and dislikes:

Does your child have any dietary needs?

O Yes O No

If yes, please explain: _____

Does your child have any known allergies? If yes, an Allergy Information Form must be completed. O Yes O No

Communication

At home we speak: _____

Has your child been introduced to infant sign language? O Yes O No

I communicate my needs by:

What makes me happy when I'm sad?

My favorite activities include:

Does your child have any medical needs?

O Yes O No

If yes, please explain: _____

_____

Does your child have a development, emotional, or physical disability? If yes, an Individual Child Care Program Plan will be developed between the parent and the Director.

O Yes O No

Little Eagles Daycare

Infant Written Dietary Instructions

Child's Name:_____ **Birthday:**_____ **Date:**_____

Daily Feeding Schedule:

Time	What is Fed	Amount

Special Feeding Instructions

Type of feeding: ☐ Breast Milk ☐ Formula

Brand of Formula:_____

Type of Water (indicate cold or warm):_____

Type of Bottle and Nipple, or Cup:_____

Iron Fortified, dry plain infant cereal: ☐ Rice ☐ Oatmeal ☐ Barley

Number of Tablespoons:_____ Mixed with:_____

Solid Baby Food (please check all that apply)

Fruit: ☐ Apple ☐ Banana ☐ Peach ☐ Pear ☐ Prune

Other:_____

Vegetables: ☐ Carrots ☐ Green Beans ☐ Peas ☐ Squash ☐ Sweet Potato

Other:_____

Modified Table Food Instructions

Served hot lunch from MMN Elementary School? If yes, review lunch menu daily to determine if a cold lunch is needed (brought from home). ☐ Yes ☐ No

Modification of texture needed? ☐ Strained ☐ Mashed ☐ Chopped ☐ Soft Cooked ☐ Cut ☐ None Needed

Will you allow 100% fruit juice? (ages 12 months – 16 months) ☐ Yes ☐ No

If yes, number of ounces?_____

Meat or meat alternate? ☐ Plain Meat ☐ Fish ☐ Poultry ☐ Egg Yolk ☐ Cooked Dry Beans ☐ Dry Peas ☐ Cheese Cottage Cheese

☐ I have attached other special dietary needs

Parent Signature:_____ Date:_____

DEPARTMENT OF EDUCATION

Infant Meal Notification Letter

To: Parents and guardians of infants under one year of age

From: Provider: Little Eagles Daycare - ISD 2853

All children enrolled in this family day care home, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Family day care homes who participate in this program are reimbursed by USDA to help with the cost of serving nutritious meals that meet CACFP guidelines to all enrolled children. To fully meet CACFP requirements, this provider is required to offer at least one formula and other required infant foods* to enrolled infants until they turn one year of age.

The iron-fortified infant formula this provider offers is: Parent's Choice Soy, Gentle, Advanced

***Other infant foods supplied by this provider include:** iron-fortified infant cereal; meat/meat alternates; fruits and vegetables; and bread, crackers, or ready-to-eat cereal. More details about what is creditable can be found in the CACFP Infant Meal Pattern

You may choose to supply one item for your infant. For example, you may come to the facility to breastfeed your child or bring your own breastmilk or iron-fortified infant formula. If the provider supplies the iron-fortified formula, you may bring one other infant food that meets the CACFP Infant Meal Pattern requirements. A copy of the CACFP Infant Meal Pattern is printed on the back of this letter. The provider will claim reimbursement for your infant's meals when a meal contains only breastmilk or iron-fortified infant formula regardless of who supplies it. Please note that the provider will also introduce semi-solid foods to your infant according to the decisions made by you and your infant's doctor. It is recommended that breastmilk or iron-fortified formula is the only food until your child shows developmental readiness for additional foods at about 6 month of age.

Please check your preferences:

Formula or Breastmilk: (check one)

- ☐ I want the provider to supply formula for my infant.
- ☐ I will provide the following formula for my infant: _____
  Note: I understand that I will need to submit a Special Diet Statement if I provide a low-iron infant formula or other special formula for my infant.
- ☐ I will provide breastmilk for my infant.

Solid Food: (check one)

- ☐ I want the provider to supply all solid foods for my infant when he/she is developmentally ready.
- ☐ I will provide one infant food item for my infant. This may be breastmilk, formula, or a solid food item that meets the CACFP Infant Meal Pattern requirements.
- ☐ I will provide two or more food items for my infant and thus decline the CACFP.

Infant's name: _____ Birthdate: _____

Parent/Guardian signature: _____ Date: _____