

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

First date contract begins \_\_\_\_\_

Preschool Care & Early Education (34 months until first day of kindergarten)

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, Morning Snack, Lunch, and Afternoon Snack

\*\*Please see Parent Policies 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

Full Day/5-Day per Week: \$155.00/week

Full Day/4-Day per Week: \$129.00/week

Full Day/3-Day per Week: \$98.00/week

**Drop-In: \$36.00/day**

Attends AM/PM Head Start:

5-Day: \$103.00/week

4-Day: \$88.00/week

3-Day: \$67.00/week

**Drop-In: \$26.00/day**

Attends Full Day Head Start:

5-Day: \$75.00/week

4-Day: \$65.00/week

3-Day: \$50.00/week

**Drop-In: \$20.00/day**

Estimated Drop-Off Time

Estimated Pick-Up Time

Monday \_\_\_\_\_

Tuesday \_\_\_\_\_

Wednesday \_\_\_\_\_

Thursday \_\_\_\_\_

Friday \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Lac qui Parle Valley observes the following holidays: New Year's Day, Memorial Day, 4<sup>th</sup> 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 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Unless withdrawn or age eligible to transition to a different group, this contract is valid from the start of enrollment until 1/1/2020.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

<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** \_\_\_\_\_

# 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
<b>Required</b> (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)						
<b>Diphtheria, Tetanus, and Pertussis (DTaP, DTP)</b> • 3 doses during 1st year (at 2-month intervals) • 4 <sup>th</sup> dose at 12-18 months • 5 <sup>th</sup> dose at 4-6 years <i>Indicate vaccine type: DTaP or DTP</i>						5th dose not required if 4th dose was given on or after the 4th birthday
<b>Polio (IPV, OPV)</b> • 2 doses in the first year • 3 <sup>rd</sup> dose by 18 months • 4 <sup>th</sup> dose at 4-6 years					4th dose not required if 3rd dose was given on or after the 4th birthday	
<b>Measles, Mumps, and Rubella (MMR)</b> • Required for children 15 months and older • 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday • 2 <sup>nd</sup> dose at 4-6 years						
<b>Haemophilus influenzae type b (Hib)</b> • 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						
<b>Varicella (chickenpox)</b> • Required for children 15 months and older • 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday • 2 <sup>nd</sup> dose at 4-6 years						
<b>Pneumococcal Conjugate Vaccine (PCV)</b> • Required for children age 2 - 24 months • 3 doses in the first year • 4 <sup>th</sup> dose after 12 months • At least 1 dose is recommended for children 24-59 months in child care						
<b>Hepatitis B (hep B)</b> • 2-3 doses in the first year • 3 <sup>rd</sup> dose (final dose) by 18 months						
<b>Hepatitis A (hep A)</b> • 2 doses separated by 6 months for children 12 months and older						
<b>Recommended</b>						
Rotavirus (2-3 doses between 2 and 6 months)						
Influenza (annually for children 6 months or older)						

Name \_\_\_\_\_

**Instructions, please complete:**

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

**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 occurred 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:

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



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*Child's Name*

*Date of Birth*

**My Sleeping Habits:**

**Toileting Habits/Preferences:**

**My eating schedule:**

**My special food likes and dislikes:**

**Does your child have any dietary needs?**

Yes  No

If yes, please explain: \_\_\_\_\_

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

**Communication**

At home we speak: \_\_\_\_\_

What makes me happy when I'm sad?

My favorite activities include:

Does your child have any medical needs?

Yes       No

If yes, please explain: \_\_\_\_\_

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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.

Yes       No