Mi Familia Child Care Enrollment Agreement

Child's name:				Nickname:		
Date of birth:		First date of care:		Gender:	☐ Male ☐ Female	
Address:						
City:				State:	ZIP:	

Parent/Guardian Information

Parent/Guardian name:					
Relationship to child:		Resides with child?	☐ Yes ☐ No		
Home address:					
City:		State:		ZIP:	
Cell phone:		Home phone:			
Email:					
Employer:		Work phone:			

Parent/Guardian name:					
Relationship to child:		Resides with child?	☐ Yes ☐ No		
Home address:					
City:		State:		ZIP:	
Cell phone:		Home phone:			
Email:					
Employer:		Work phone:			

Emergency Contact Info.

Please include at least 2 contacts that do not live with the child

Contact Person 1:	
Relationship to Child:	
What does you child call this person?	
Primary Phone:	Secondary Phone:
Address:	

Contact Person 2:	
Relationship to Child:	
What does you child call this person?	
Primary Phone:	Secondary Phone:
Address:	

Contact Person 3:	
Relationship to Child:	
What does you child call this person?	
Primary Phone:	Secondary Phone:
Address:	

Contact Person 4:	
Relationship to Child:	
What does you child call this person?	
Primary Phone:	Secondary Phone:
Address:	

The above listed people are authorized to pick-up my child from care and may be contacted in case of emergency or illness if I can not be reached.

Guardian Signature: _____

Additional People Authorized to Pick Up

Name:
Relationship:
Phone:

Name:
Relationship:
Phone:

Back Up Care Provider

Name:	Primary Phone:	Secondary Phone:

Persons Specifically NOT Authorized to Pick Up

Our program must have a copy of the legal custody agreement or protection order on file to withhold a child from a parent or legal guardian

Name:
Relationship to Child:
What does you child call this person?
Notes:

Name:
Relationship to Child:
What does you child call this person?
Notes:

Consent for Medical Care and Treatment

I give consent for the licensed provider or qualified staff to administer first aid to my child/children.

Guardian Signature: _____

If I cannot be contacted in the event of an emergency, I authorize and consent to any emergency medical care, treatment, or procedure to be to be preformed for my child by a licensed physician, health care provider, or EMT as they deem necessary to safeguard my child's health. I wave my right to informed consent for such treatments. I also give permission for my child to be transported by ambulance to an emergency center for treatment.

Guardian Signature: _____

Child's Medical Coverage

Primary Insurance Company Name:	Policy Number:
Policy Holder's Name:	Employer/Group Name:

Secondary Insurance Company Name:	Policy Number:
Policy Holder's Name:	Employer/Group Name:

Child's Medical Care Providers

Primary Care Doctor:	Phone:
Clinic address:	Fax:

Dentist:	Phone:
Dental clinic address:	Fax:

Medical Acknowledgements

If I cannot be reached or the situation warrants immediate action, I authorize program staff to:

- contact the medical or dental provider above and discuss the situation.
- administer first aid or CPR;
- allow my child to be taken by ambulance or other emergency medical service to a medical care facility.
- allow my child to receive emergency medical or dental treatment that is deemed necessary by a licensed medical or dental provider.

Medical Information

When you enroll your child, we need a copy of your child's immunization records and any other health information required by licensing.

Allergies

Medication allergies:		Life-threatening reaction:	☐ Yes ☐ No
Food allergies:		Life-threatening reaction:	☐ Yes ☐ No
Other allergies:		Life-threatening reaction:	☐ Yes ☐ No

If any of the allergies are life-threatening, you will need to complete an Allergy Care Plan.

Medications

Daily prescriptions medications:	
Daily nonprescription medications:	
Does program need to administer any medication?	☐ Yes ☐ No

If the program needs to administer medication, you will need to provide written instructions either from yourself or a health care provider and complete a Medication Administration Form. You also must provide the medication in its original container (with the label from the pharmacy for prescription medications)

About Your Child

Has your child be in childcare before? If so what type? *(family childcare, childcare center, grandma, etc...)* _____

_____

How does your child feel about school/ daycare and being away from you? _____

_____

_____

What experiences has your child had in groups of children? _____

_____

What is your child's temperament generally like? *(are they shy, easy going, easily upset, etc...)* _____

_____

_____

What is your normal method of discipline at home? _____

_____

How does your child handle disappointment or frustration? _____

_____

Does your child usually nap? At what time? _____

Does your child have a security objects such as a blanket, doll, or pacifier? _____

Are there any food restrictions for your child? _____

_____

What are your child's favorite foods? _____

What foods does your child dislike? _____

Is your child potty trained? *(Goes most days without an accident)* _____

How does your child let you know they need to use the bathroom? _____

What word does your child use for: Bowel movements: _____ Urination: _____

What languages are spoken at home? _____

What are your child's favorite toys, activities, or games? _____

_____

What else would you like me to know about your child or family? _____

_____

_____

_____

_____

Child's Health Info.

** A copy of your child's immunization record and most recent physical/ Statement of Health may also be required **

How is your child's health generally? _____

Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Exempt

Does your child have any known allergies? _____

Does your child have any medical conditions we should be aware of? _____

Is your child on any medications that we should know about? _____

Does your child have any physical disabilities? _____

Does your child have any issues with their speech, vision, or hearing? _____

Does your child have any issues with their motor skills, balance, or coordination? _____

Does your child have any learning disabilities or issues regarding their cognitive, social, or emotional development? _____

Do you have any other concerns about your child's physical, cognitive, or emotional development? _____

Mi Familia

NAME RELEASE

I give permission to have my child's name printed on the class roster to be distributed to parents of children in the class and staff. (I.E. Valentine's Day list, etc.)

Signed: _____ Date: _____

PHOTOGRAPHS

I hereby give my permission for my child to be photographed in the program in the program, at program functions, fieldtrips and for the photographs to be displayed and/or used on the Mi Familia Child Care Website or Facebook page. I understand that the photographs may be taken by school staff, professional photographers, news media and other parents.

Photo Release

Signed: _____ Date: _____

IMPROMPTU WALKS

I hereby give permission for my child to go on impromptu walking field trips in the neighborhood.

Signed: _____ Date: _____

Mi Familia

Child Background Form

Please describe your child's eating, communication and comforting habits and methods:

Does your child have special needs or receive special services?

Do you allow Mi Familia to put sunscreen on your child?

Do you allow Mi Familia to put insect repellent on your child?

Please provide information on your child's family, race, religion and language spoken in your home to have a better understanding of your cultural beliefs.

Is your child receiving any support services?	☐ Yes ☐ No
What type of services?	
Will your child receive services here?	☐ Yes ☐ No
Other comments:	

Schedule

What days will your child attend?	☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
What times will your child attend?	Drop-off ____:____ Pick-up ____:____
What meals will your child eat?	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack ☐ Supper ☐ Evening snack

Transportation

Will the program need to provide transportation?	☐ Yes ☐ No	
Pick-up:	Address:	Time:
Drop-off:	Address:	Time:
Notes:		

Parent/Guardian Signature

Printed name:

Signature: Date:

Program Signature

Printed name:

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

ProvidersChoice
Supporting the Child Care Professional

CACFP: ANNUAL Child Enrollment & Household Income Statement

Center Name: MI FAMILIA CHILDCARE #163 | First Day in Care:

STEP 1 List all children in the household

First Name	Last Name	Date of Birth	Enrolled in center?	Foster child?	Hours in Care		Normal Days In Care							Normal Meals Received						Ethnicity*	Race**
					Arrive	Leave	M	Tu	W	Th	F	Sa	Su	B	AM	L	PM	D	EV		

Ethnicity* Optional to complete — **H**: Hispanic or Latino -OR- **N**: Not Hispanic or Latino

Race** Optional to complete — **I**: American Indian or Alaskan Native, **A**: Asian, **B**: Black or African American, **P**: Native Hawaiian or other Pacific Islander, **W**: White

STEP 2 Infants

Infant's Name:

☐ Parent will provide more than 1 food item per meal/snack and decline the CACFP

☐ Center will provide formula — The type of iron-fortified infant formula this center offers:

☐ Parent will provide breastmilk — ☐ Parent will provide iron-fortified infant formula. *Specify brand & type:*

STEP 3 Do any household members currently participate in: ☐ **SNAP?** ☐ **MFIP?** ☐ **FDPIR?** If YES, **Case Number:**

STEP 4 Complete if you do not have a case number

Adults – Full Name List all adult household members even if they don't receive income.	Gross Pay		Farm or Self-Employment		Public Assistance, Child Support, Alimony		All Other Incomes	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	
How Often	**W**: Weekly, **B**: Bi-Weekly (every other week), **2**: Twice a month, **M**: Monthly, **Y**: Yearly				Child Income		$	

STEP 5

I certify (promise) that all information on this form is true and that all income is reported. I understand this information is given in connection with receipt of federal funds and that officials may check the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.

Print Name | Last 4-digits of Social Security Number SSN (if STEP 4 is completed): | ☐ No SSN

Signature | Date | Phone

Address | City, State, Zip Code

Email

SPONSOR USE ONLY

☐ Free (A) – Foster ☐ Free (A) – Case Number ☐ Free (A) - Income ☐ Reduced (B) - Income ☐ Paid (C) **Income:** How Much _____ How Often _____ HH Size _____

1/19 Effective Dates TO Signature _____ Date _____ 2nd Approval _____