



Enrollment Form

10.19.16

Child Information

For office use only
Registration fee paid _____
Entered into the computer _____
Name on roll call sheet _____
Copy for classroom _____
Food program sheet _____
IEF Form _____
Shot Records _____
Start Date _____
Authorization for Child Care Assistance _____

Child's Name _____ Birth date _____ Gender _____

Child's Name _____ Birth date _____ Gender _____

Child's Name _____ Birth date _____ Gender _____

What days and times will your child be attending our center?

Monday	Tuesday	Wednesday	Thursday	Friday
____:____	____:____	____:____	____:____	____:____
____:____	____:____	____:____	____:____	____:____

Parent Information

Name _____

Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Social Security Number (last four digits) ***-**-_____

Employer _____

Position _____

Work Phone _____

May we call you at work? _____

Marital Status: Single Married Separated

Name _____

Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Social Security Number (last 4 digits) ***-**-_____

Separated

Employer _____

Position _____

Work Phone _____

May we call you at work? _____

Marital Status: Single Married

The child lives with (circle one) **Mother** **Father** **Both** **Other:** _____

If there is a non-custodial parent, are they allowed to pick the child up? **YES** **NO**

Who else can pick up your child? (Please note that we will ID the person picking up the child/children)

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Emergency Contact Information: In the event of an emergency who will be contacted?

Name _____ Name _____ Name _____
Phone _____ Phone _____ Phone _____
Other Number _____ Other Number _____ Other Number _____

Relation to child _____ Relation to child _____ Relation to child _____

Consent for Emergency Medical Care

I/We _____ Relation _____ of _____
Your Name Child's Name

Do Hereby request and give consent to the Director of Little Hands at Work and Play for said child to receive such medical aid as may be deemed necessary expedient by a duly licensed or recognized physician in case of an emergency when parent(s) cannot be reached. Consent is also given for the Director to transport said child for emergency medical treatment, if parent(s) cannot be reached.

Parent/Guardian Signature Date Witness Date

Notification for Release of Publication

Release for publication must be on file for everyone in photographs. Please choose one of the following.

_____ I freely grant consent to Little Hands at Work and Play to photograph me and/or my child/children (no names will be used). Little Hands at Work and Play can use the photos for publicizing activities of the center through Little Hands at Work and Play website and Social Media without expectation of payment to myself &/ or family.

_____ I do not grant consent to Little Hands at Work and Play to photograph me and/or my child/children.

Parent/Guardian Signature Date

Title XX (state aid) Co-pay for each month: \$ _____
Authorization Number: _____
Circle one (if any) SNAP, TANF, or FDPIR: Case Number _____

Permission to Transport

I give Little Hands at Work and Play permission to transport my child in the Little Hands van to and from school and activities. This includes field trips that are planned by the center.

Parent/Guardian Signature Date

Your child's/children's personal articles...While our Little Hands' staff will do their best to secure personal articles, Little Hands at Work and Play is not responsible for lost or broken personal items. For example, put limit to: toys, glasses, jewelry, and clothing items. Please do not allow your child to bring toys except on Fridays for show- n-tell. Bringing toys is very disruptive to your child's daily routine. We do not allow outside food in the center unless preapproved by the Director for a special occasion, due to allergies and the policies of the Child and Adult Care Food Program.

Child's name _____

Parent/Guardian _____ Date _____

I certify that the above information is correct to the best of my knowledge.

Parent/Guardian Signature Date

Immunizations:

Nebraska: A copy of your child (ren)'s current immunizations must be kept on file at Little Hands at Work and Play. Each time your child receives immunizations please send an updated copy to the center.

Iowa: Your child (ren)'s current immunizations must be completed on the Iowa Department of Health Certificate of Immunization found in the parent packet. Each time your child receives immunizations please send an updated copy to the center.

History: Vision impairment/Eye infections? _____ Hearing impairment/Ear infections? _____ Speech Problems? _____

Pediatrician _____

Phone # _____

Dentist _____

Phone # _____

Insurance _____

Phone # _____

I certify that the above information is correct to the best of my knowledge,

Signature

Date

Does your child have any allergies or sensitivities of which we should be aware of? (Milk, food, latex, bee stings)

Please share with us any other information that you think might help us take the best care of your child/children.

Dear Parents,

One of our goals at Little Hands at Work and Play is to provide a safe environment for your child/children. In order to assure that your child receives adequate care while they are here, we are asking that you make sure your child/children are attending on a full time basis. When a child is not full time and their schedule is not consistent, it makes it difficult for us to staff accordingly. You will be responsible for payment on the days that your child/children do not attend. This will enable us to be able to provide adequate staff. Sorry for any inconvenience this may cause. If you have any questions, please feel free to contact me at any time.

I _____ agree to bring my child to Little Hands at Work and Play on the days and times set forth below. If I do not bring my child on the scheduled days and times I understand that my care may be terminated and my spot will be given to the next family on the wait list.

Schedule Days and Times

Monday	Tuesday	Wednesday	Thursday	Friday
____:____	____:____	____:____	____:____	____:____
____:____	____:____	____:____	____:____	____:____

Signature: _____ Date: _____

Annual Update:

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____