Enrollment Forms List

☐ **Preschool** ☐ **Afterschool** ☐ **Summer Enrichment**

Child's Name: _____

Parent's Name: _____

Forms	Comments
1. ☐ **DILC** Enrollment Form ☐ $30.00 Enrollment Fee	
2. ☐ **Care4Kids** Application	
3. ☐ **Care4Kids** Parent Provider Agreement	
4. ☐ 4 Current Paychecks (If applying for Care4Kids)	
5. ☐ Parent Page of Health Assessment (if not included with Students Health Assessment)	
6. ☐ Student Health Assessment (receive from Doctors Office)	
7. ☐ Immunization Record	
8. ☐ Potassium Iodide Authorization Form	
9. ☐ Permission/ Release Forms	
10. ☐ Income Eligibility Form (Nutrition)	
11. ☐ NESS Form	
12. ☐ Behavior Agreement (School-Age only)	
13. ☐ Home Language Survey	
14. ☐ Authorization for Administration of Medication (if applicable)	
15. ☐ Developmental History (Preschool)	
16. ☐ Sunscreen (Summer Program)	
17. ☐ Horse Sense Application (Summer Program if applicable)	

The Center: A Drop-In Community Learning & Resource Center

P.O. Box 848 ● New London, CT 06320
Tel: 860.442.4466

Application fee: $30(non-refundable)

For Office Use Only
Start Date:

ENROLLMENT FORM

Program Selection:

☐ Before Care (6:30am-8:00am)

☐ After School Enrichment (K-5th grade)

☐ Summer Enrichment (K-8th grade)

☐ Early Childhood Education

Child's Name	Birth Date	Age	Gender ☐ Male ☐ Female
Home Address			Telephone #
Child's School Name (If School Age):			Child's Current Grade:
Mother's/Guardian's Name			Home #
Home Address			Cell #
Email Address			
Place of Employment			Work #
Employment Address			
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Do you speak another language at home other than English? ____ NO ____ YES (Specify) _____			
Father's /Guardian's Name			Home #
Home Address			Cell #
Email Address			
Place of Employment			Work #
Employment Address			
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Do you speak another language at home other than English? ____ NO ____ YES (Specify) _____			

The Center: A Drop-In Community Learning & Resource Center

The following information is essential for our Donors and Funding Community.

Please select a "Race" and answer yes or no under Hispanic/Latino and if you answer yes; please provide your child's Ethnicity/Country of Origin.

"Race Categories"	Hispanic or Latino		Ethnicity/Country of Origin
☐ White	☐ NO	☐ YES	_____
☐ Black /African American	☐ NO	☐ YES	_____
☐ Asian	☐ NO	☐ YES	_____
☐ American Indian/Alaskan Native	☐ NO	☐ YES	_____
☐ Native Hawaiian/ Other Pacific Islander	☐ NO	☐ YES	_____
☐ Asian & White	☐ NO	☐ YES	_____
☐ Black/African American & White	☐ NO	☐ YES	_____
☐ American Indian/Alaskan Native & White	☐ NO	☐ YES	_____
☐ American Indian/Alaskan Native & Black African American	☐ NO	☐ YES	_____
☐ Other Multi Racial: _____	☐ NO	☐ YES	_____

Is this child a ward of the state? ☐ Yes ☐ No

If Yes,

Social Worker's Name_____ Phone #_____

Emergency Contact Information: ***At least Two (2) contacts other than the legal guardians***

Primary emergency contact and pick-up name (*cannot be guardian*):	Home #
	Cell #
Address	Work #
Email Address	
Relationship to Child	

The Center: A Drop-In Community Learning & Resource Center

Secondary emergency contact and pick-up name (*cannot be guardian):*	Home #
	Cell #
Address	Work #
Email Address	
Relationship to Child	

#3 emergency contact and pick-up name (*cannot be guardian):*	Home #
	Cell #
Address	Work #
Email Address	
Relationship to Child	

#4 emergency contact and pick-up name (*cannot be guardian):*	Home #
	Cell #
Address	Work #
Email Address	
Relationship to Child	

Physician Name_____ Physician Phone Number_____

Physician Address_____ City/State/Zip _____

Dentist Name _____ Dentist Phone Number _____

Dentist Address_____ City/State/Zip _____

The Center: A Drop-In Community Learning & Resource Center

General Release

Child First Name: _____ **Child Last Name:** _____

I, _____, the legal guardian of _____
(Print Legal Guardian's Name) **(Print Child's Name)**

Hereby release *The Center: A Drop-In Community Learning & Resource Center program*, and any organization with which it might contract for services, from any and all liability for any injury that might befall my child during *The Center: A Drop-In Community Learning & Resource Center* programs and activities. I understand that this program is educational and recreational and I hereby certify my child is in good health and may participate in all aspects of program activities except as stated in writing and included on this form.

I give permission for my child to participate in:

- My child care provider, has my permission to transport my child, if necessary, when my child is in care.
- Field trips either walking, in the van or bus.
- Computer classes and I will review the Parent Handbook policies and procedures and discuss the policies and the acceptable use of the computer and internet with my child/children.

I authorize the New London Public School District to give any and all medical and/or educational records concerning my child to *The Center: A Drop-In Community Learning & Resource Center*. I understand that this information will be used to meet state health requirements and to evaluate the academic and fitness needs and performance of my child. I further give consent to *The Center: A Drop-In Community Learning Center* to assess the impact of programming on my child's academic progress and social development through research and use of evidence based practices.

I authorize *The Center: A Drop-In Community Learning & Resource Center* the right to use photographs and other records of my child's likeness, voice, and sounds during his/her participation, and to reuse or license the right to reuse such photographs and recordings of his/her name, likeness and biography, in all media and in all forms, including, but not limited to, his/her participation in programs and activities, without compensation to me or any limitation whatsoever.

Behavior Management- We promote a positive system of behavior management based on praise, humor, modeling, redirection, and choice. If a child does not respond to these strategies, the staff member will issue a verbal warning. If the behavior continues, issue a second warning and indicate the consequences if the behavior continues. After the second warning staff may:

- Initiate a time-out for a period of time that is age-appropriate (number of minutes not to exceed the age of the child)
- Limit participation in activities
- Revoke privileges
- Contact the parent

The following behaviors will not be tolerated: fighting, stealing, vandalism, intimidation, extortion, and defiance. Consequences for such behavior may include:

- Suspension from the program
- Reparation of damages
- Dismissal from the program
- Log any intervention in the participant's file.
- Following any disciplinary intervention, ask the child to identify the behavior that warranted the intervention as well as appropriate behaviors to use next time.

Methods of Discipline:

- Children will be encouraged to think of solutions or alternatives for their own misbehavior. This enables the child to accept responsibility for their own actions.
- Children will be redirected from aimless, inappropriate behavior to a more constructive, successful experience by using appropriate choices.
- Children will be removed from a provoking situation. This technique gives children the opportunity to gain control of him/her self. If the child becomes out of control and/or poses a danger to him/her self or other children, he will be sent to the Head Teacher or the Executive Director. The objective is to preserve the child's self-esteem, not to exploit or demean the child. The child decides how long he/she needs before returning to the group.

I authorize *The Center: A Drop-In Community Learning & Resource Center*, to have any and all necessary medical care provided to my child in case of an emergency. I understand that I will be contacted as soon as possible, should such emergency arise.

Guardian's Signature_____ **Date:** _____

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
School/Grade	Race/Ethnicity: ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other	
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

POTASSIUM IODIDE (KI)

STUDENT MEDICATION AUTHORIZATION FORM

(PLEASE COMPLETE A SEPARATE FORM FOR EACH ENROLLED STUDENT/CHILD)

NAME OF STUDENT: _____

ADDRESS: _____

DATE OF BIRTH: _____ SCHOOL: *The Center: A Drop-In Learning & Resource Center*

NAME OF PARENT/GUARDIAN: _____

HOME TELEPHONE: _____ DAY TELEPHONE: _____

STUDENT'S PRIMARY CARE PHYSICIAN: _____

PRIMARY CARE PHYSICIAN TELEPHONE: _____

(Please indicate your authorization or refusal by checking the appropriate box(es) below.)

☐YES, I want my above named child to be administered potassium iodide (KI) by *The Center: A Drop-In Learning & Resource Center* personnel in the event of a nuclear emergency and upon order of the Commissioner of the Department of Public Health.

☐NO, I do NOT want my above named child to be given potassium iodide (KI) by school system personnel in the event of a nuclear emergency, even if ordered by the Commissioner of the Department of Public Health for the following reasons:

(1) Due to medical condition(s) such as those indicated below:
- Allergy to iodide
- Thyroid problems (Thyroid problems can include: Grave's disease, Goiter, Hypothyroidism, or any other condition of the thyroid gland.)
- Hypocomplementemia Vasculitis (A severe skin condition which includes bleeding under the skin, fluid-filled blisters, sores, and burning.)

(2) For other than medical reasons, I do not want my child to receive KI.

I understand that this authorization will remain in effect for as long as my child is enrolled in *The Center: A Drop-In Learning & Resource Center*. I also understand it is my responsibility to notify *The Center: A Drop-In Learning & Resource Center* in writing if I desire to change my authorization as indicated above.

_____ _____

(Date) (Parent/Guardian Signature)

Permission Release Form

Acknowledgement of:

First Aid / CPR • Behavior Management • Field Trips • Photos and Videos

Name of Child: _____ Date: _____

First Aid and CPR Permission

I acknowledge that I have read the Accident and Emergency policy in the parent handbook and I give the Drop staff permission to administer First Aid and/or CPR to my child.

_____

Signature of Parent/Guardian

Discipline Policy and Behavioral Guidance

I acknowledge that I have read the Discipline Policy and Behavioral Guidance in the parent handbook and I give the Drop staff permission to use appropriate measures as stated in the handbook.

_____

Signature of Parent/Guardian

Field Trips

I acknowledge that I have read the Field Trip Policy in the parent handbook and I will follow the stated procedures.

_____

Signature of Parent/Guardian

Photo Release

I give consent to the use of photographs/videos taken during our programs for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use.

____ Yes, I give consent for The Drop-In Learning Center/Camp to photograph my child for program purposes and/or events.

_____No, I do not authorize to The Drop-In Learning Center/Camp to photograph for my child for any event.

_____

Signature of Parent/Guardian

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS AND HEAD START

For instructions, see *Instructions for Income Eligibility Application for Child Care Centers and Head Start.*

PART 1 — CHILD'S INFORMATION

Child's Name: _____ Age: _____ Birth Date (*month, day, year*): _____

Child's Normal Child Care Schedule (***Check all days that apply):***

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Child's Normal Hours of Care ***(Include time and circle AM or PM):***

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal Meal Services Provided to Child ***(Check all meals/snacks that apply):***

☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper

PART 2A — PARTICIPANTS CATEGORICALLY ELIGIBLE AS FREE FOR CACFP BENEFITS

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children: Complete this part and part 3. Do **not** complete part 2B.

SNAP Case Number: _____ TFA Case Number: _____ Check if foster child: ☐

PART 2B — ALL OTHER HOUSEHOLDS

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List everyone in the household, including the child listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the **amount of income** in the appropriate frequency box. *You **must** place the income in the appropriate frequency box.*											
	Earnings from Work (before deductions) – Job 1				**Public Assistance/ Alimony/Child Support**				**Pensions/Retirement/Social Security/All Other Income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

PART 3 — CONTACT INFORMATION, SIGNATURE AND SOCIAL SECURITY NUMBER

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed Name of Adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ ☐ I do not have a SSN

Home Telephone: _____ Work Telephone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

CACFP INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS AND HEAD START, continued

PART 4 — RACIAL AND ETHNIC IDENTITY (OPTIONAL) *You are not required to complete this part.*

Ethnicity ***(Check one):***
- ☐ Hispanic/ Latino
- ☐ Not Hispanic/Latino

Race ***(Check one or more):***
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits.. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

FOR SPONSOR USE ONLY – DO NOT WRITE BELOW THIS LINE

Annual Income Conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a Month X 24 • Monthly X 12

Total family income: $ _____ Family size: _____ **OR** ☐ SNAP/TFA household ☐ Foster Child

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor Eligibility Official: _____ Date: _____
Signature

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

For information on the CACFP, visit the CSDE's CACFP website or contact the CACFP staff in the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103.

This form is available at
http://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/IEAppCenter.pdf.

Behavior Agreement

Child's Name: _____

The Drop-In Learning Center is a place where individual differences are valued, where people are supported in reaching their goals and accomplishing challenges, and where everyone can have fun. Creating such an atmosphere requires the commitment of all participants. We ask everyone to agree to the behavior expectations listed below. Children and parents/guardians should review and discuss these guidelines together.

I Will Show Respect for Others

- I will respect other people's space, ideas and values, even if they are different from my own.
- My actions and language will have a positive impact on others.
- I understand that any behavior that could harm (physically or emotionally) another child or staff member, or which is disrespectful, is unacceptable at The Drop.

I Will Show Respect for Myself

- I will make the most of learning opportunities at The Drop by participating fully in activities, and I will try new things and have a positive attitude.
- I will not allow exclusive relationships (like those with friends from home or school) to prevent me from getting to know other people at The Drop, or from including others in activities.
- I will stay with my group and always ask a staff/instructor before leaving the group.

I Will Show Respect for The Environment and The Drop Facilities

- I understand that I'm expected to share responsibility for keeping personal and community areas neat and clean.
- I will pick up litter, and not damage or remove anything from the environment.
- I will take care of The Drop's facilities and/or any other facility that the Drop uses (i.e. Conn. College, Expressiones, Ness, Library, etc.) program supplies, and equipment.
- I will put materials and equipment away when I finish using it.

I Will Show Respect for Everyone's Health and Safety

- I understand that the possession and use of tobacco, alcohol, or illegal drugs is prohibited. I will not have/use these at The Drop.
- I understand that fireworks, firearms, pocket knives, and other weapons are not allowed. I will not bring these to The Drop.
- I will abide by all safety standards explained by the staff/instructor.
- I understand that physical and emotional bullying or violence will result in my immediate dismissal from The Drop.

over

If a child has difficulty following The Drop's behavior expectations, Drop staff will:

- remind the child of expected behavior.
- review the Behavior Agreement.
- Notify Parents/Guardians with a written and verbal notification.

If a pattern of inappropriate behavior continues, The Drop staff will work with the child to set specific, appropriate behavior goals and outline consequences for continued inappropriate behavior.

If inappropriate behavior of any kind (such as physical or emotional violence, bullying, or possession of prohibited items) is not brought under control within two (2) weeks or less it will result in immediate dismissal from the program and all fees paid will be forfeited. The parent/guardian is responsible for picking up a dismissed child immediately.

_____ _____

Signature of Student Date

_____ _____

Signed Name of Parent/Guardian Date

By signing this agreement all parties agree to the stipulations in the document and will following accordingly.

Home Language Survey

The Drop would like all families to share the language(s) spoken in each child's home to identify their specific language needs. This information is essential for schools to provide meaningful instruction for all families. If a language other than English is spoken in the home, please help us by filling out the information below. Thank you for your assistance.

STUDENT INFORMATION

Child's First Name_____ Child's Last Name _____

Date of Birth_____ Country of Origin_____

QUESTIONS for PARENTS /GUARDIANS

1.What is the native language (s) of each parent/guardian? (check one)

_____ _____

Mother ☐ Father ☐ Guardian ☐ Mother ☐ Father ☐ Guardian ☐

2. What language did your child first understand and speak? _____

3. Which other languages does your child know? (check all that apply)

_____ Speak ☐ Read ☐ Write ☐

_____ Speak ☐ Read ☐ Write ☐

4. Which languages does your child use? _____

5. Will you require written information from school in your native language? Yes ☐ No ☐

6. Will you require an interpreter/translator at Parent-Teacher meetings? Yes ☐ No ☐

_____ _____

Parent/Guardian Signature Date

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? ☐ YES ☐ NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects.

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Development History

Please fill out this Development Record, it will be a great help to us to serve you and your child's needs.

Name of Child: _____ Date of Birth: _____

Describe your child briefly (physical appearance, personality, abilities):

_____

_____

_____

Any allergies? _____ If yes, please list: _____

_____

Was your pregnancy with this child full term? _____

If not, at what gestation did delivery occur? _____

Is your child's skin highly sensitive? _____

Describe your child's typical daily schedule: _____

_____

_____

Is your child a finicky eater? _____

Are bowel movements regular? _____ How many times a day? _____

How frequent do accidents occur? _____

BEHAVORIAL DEVELOPMENT

Does your child have a "fussy" time? _____ When? _____

How is the time handled? _____

_____

(over)

Who does most of the disciplining? _____

What frightens your child?

Animals _____Loud Noise _____ Darkness_____ Storms _____ Rough children _____

Anything else _____

Favorite toys and activities at home: _____

Does he/she like to read? _____ Listen to music _____

Does he/she prefer to play outdoors? _____

Can he/she ride a tricycle? _____

Comments:

In what particular ways can we help your child through his/her preschool years?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent's/Guardian's Permission To Apply Sunscreen

Child's Name: _____

I give my permission for the staff at the Drop-In Learning Center or Camp Drop-In to apply the sunscreen product as specified below, when he or she will be going outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face. I have checked all applicable information regarding the type and use of sunscreen for my child:

PLEASE CHECK ALL BOXES BELOW THAT APPLY

☐ I understand that I must provide sunscreen in an original container for my child's use only. The container must be labeled with child's first and last name.

☐I understand that the sunscreen should be:

- PABA free
- SPF 15 or higher
- UVA and UVB protection
- Fragrance Free
- Spray form (recommended for easier application)

☐ I have provided the following brand/type of sunscreen for use on my child

_____

(Please list the name of the sunscreen you have provided)

☐This product has been previously applied to my child without any adverse effects. To my knowledge, my child does not have any allergies to sunscreen.

☐ I must apply the first application before drop-off in the morning. DILC staff will apply sunscreen before afternoon outside play.

☐I have taught my child how to apply sunscreen properly and my child can apply sunscreen independently.

☐ If my child needs help re-applying sunscreen; I give my permission for staff provide my child with assistance if he/she request it.

Parent/Guardian full name (print):_____

Parent/Guardian signature: _____ Date: _____