



Central Clark County  
Community Child Care Center, Inc.  
Greenwood, WI 54437

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## Enrollment

Pages 2-8 must be submitted for all children. These include:

2. General Enrollment (CFS-0062)
- 3-4. Health History (CFS-2345)
5. Health Report (CFS-0060)
6. Immunization Record (F-44912)
- 7-8. Child and Adult Care Food Program

*\*note: only one copy of page 7 needs to be submitted per household\**

An Under 2 Intake form (pages 9-12, CFS-0061) must be submitted for children under two years of age. An Infant Meal Notification form (page 13) must be submitted for infants under age one.

If a child ever requires medication, an Authorization to Administer Medication form must be submitted (page 14, CFS-0059).

Additionally, any children attending public or private school or **preschool** need an Alternate Arrival/Release form (page 15, CFS-0104).

**CHILD CARE ENROLLMENT**

**Use of form:** Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

**CHILD INFORMATION**

Name (Last, First, MI)	Address – Home (Street, City)	Telephone Number	Birthdate (mm/dd/yyyy)	First Day of Attendance
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**PARENT OR GUARDIAN** – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

Relationship to Child	Name	Address – Home (Street, City)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.
Mother					
Father					
Guardian					
Guardian					

**AUTHORIZED PERSONS** – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

Relationship to Child	Name	Address – Home (Street, City)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

**EMERGENCY CONTACT** – The person to be notified in an emergency when parents / guardians cannot be reached.  Yes  No This person is authorized to pick up the child.

Relationship to Child	Name	Address – Home (Street, City)	Home / Cell Telephone No.	Name and Address – Place of Employment OR Where Reachable While Child is in Care	Telephone No.

**PHYSICIAN OR MEDICAL FACILITY**

Name	Address (Street, City, State, Zip Code)	Telephone Number
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**AUTHORIZATION**

- Yes  No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes  No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes  No I give permission for my child to participate in field trips and other activities during operating hours.  Transported  Walking
- Yes  No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

<b>SIGNATURE</b> – Parent or Guardian	Date Signed
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### HEALTH HISTORY AND EMERGENCY CARE PLAN

**Use of form:** This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

**CHILD INFORMATION**

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

**PARENT / GUARDIAN INFORMATION** Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

Name – Physician	Address – Medical Facility	Telephone Number
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**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

**HEALTH HISTORY AND EMERGENCY CARE PLAN** If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
 

<input type="checkbox"/> No specific medical condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / seizure disorder	<input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
<input type="checkbox"/> Cerebral palsy / motor disorder		
<input type="checkbox"/> Other condition(s) requiring special care – Specify.		

  
 Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.  
 Food allergies – Specify food(s).  
  
 Non-food allergies – Specify.

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2. Triggers that may cause problems – Specify.

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3. Signs or symptoms to watch for – Specify.

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4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

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5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

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6. When to call parents regarding symptoms or failure to respond to treatment.

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7. When to consider that the condition requires emergency medical care or reassessment.

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8. Additional information that may be helpful to the child care provider.

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**SIGNATURE** – Parent or Guardian

Date Signed (mm/dd/yyyy)

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**Review dates:** \_\_\_\_\_

## CHILD HEALTH REPORT – CHILD CARE CENTERS

**Use of form:** Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

### PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)

Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

### HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

Yes  No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: \_\_\_\_\_ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

### AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)

Address (Street, City, State, Zip Code)

**SIGNATURE** – MD, PA or HealthCheck Provider

Date of Examination

## DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

### PERSONAL DATA

PLEASE PRINT

<b>STEP 1</b>	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

### IMMUNIZATION HISTORY

**STEP 2** List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

**Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.**  
 Yes year \_\_\_\_\_ (Vaccine is not required)  
 No or Unsure (Vaccine is required)

### REQUIREMENTS

**STEP 3** The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	2 Hep B	1 MMR <sup>3</sup>
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	3 Hep B	1 MMR <sup>3</sup> 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT <sup>4</sup>	4 Polio			3 Hep B	2 MMR <sup>3</sup> 2 Varicella

<sup>1</sup>If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).  
<sup>2</sup>If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.  
<sup>3</sup>MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1<sup>st</sup> birthday is also acceptable).  
<sup>4</sup>Children entering kindergarten must have received one dose after the 4<sup>th</sup> birthday (either the 3<sup>rd</sup>, 4<sup>th</sup> or 5<sup>th</sup>) to be compliant (Note: a dose 4 days or less before the 4<sup>th</sup> birthday is also acceptable).

### COMPLIANCE DATA AND WAIVERS

**STEP 4** **IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR**  
**IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).**

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

**NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.**

For health reasons this child should not receive the following immunizations \_\_\_\_\_ (List in STEP 2 any immunizations already received)

\_\_\_\_\_  
Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

### SIGNATURE

**STEP 5** To the best of my knowledge this form is complete and accurate.

\_\_\_\_\_  
SIGNATURE - Parent, Guardian or Legal Custodian

\_\_\_\_\_  
Date Signed

**THE CHILD AND ADULT CARE FOOD PROGRAM  
HOUSEHOLD SIZE—INCOME STATEMENT (CHILD CARE COMPONENT) (FFY 2015, Rev. 7/14)**

Date Received by Center \_\_\_\_\_

An adult household member must complete and return to center.

First and Last Name(s) of Enrolled Child(ren) \_\_\_\_\_

Center \_\_\_\_\_

**PART 1: BENEFITS**

If any member of your household currently receives FoodShare Wisconsin, Wisconsin Works Cash Benefits, and/or FDPIR (Food Distribution Program on Indian Reservations), check the box for the benefit currently received and provide the case number. Complete PART 3 and return it to the center's office. Do not complete PART 2. If no one receives these benefits, go to PART 2.

- FoodShare Wisconsin (10 or 16 digit #)     Wisconsin Works Cash Benefits (10 digit #)     FDPIR (9 digit #)

Case Number/Quest Card Number: \_\_\_\_\_

**PART 2: TOTAL HOUSEHOLD SIZE AND INCOME**

- List all household members, including yourself and all children.
- List all gross income (before deductions or taxes, social security, etc) on the same line as the person who receives it. (Self-employed household members should report net income.) Check the box for how often it is received. Record each income only once.  
If you provided a case number in Part 1, you do not need to provide income information.

1) Full Name	Check if Foster Child	2) Gross Income and How Often it is Received												All Other Income Received Last Month (indicate frequency)	Check if no income			
		Earnings from work before deductions	Weekly	Every 2 Weeks	Monthly	Annually	Welfare Payments, Child Support, and/or Alimony	Weekly	Every 2 Weeks	Monthly	Annually	Pensions, Retirement, Social Security, SSI, VA benefits	Weekly			Every 2 Weeks	Monthly	Annually
(Example) Jane Smith	<input type="checkbox"/>	\$ 200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$150	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$200 /annually	<input type="checkbox"/>
	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ /_____	<input type="checkbox"/>
	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ /_____	<input type="checkbox"/>
	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ /_____	<input type="checkbox"/>
	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ /_____	<input type="checkbox"/>
	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ /_____	<input type="checkbox"/>

**PART 3: ALL HOUSEHOLDS**

**Ethnicity and Race Data Collection – Completion is optional**

This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Please answer both questions.

IS YOUR CHILD(REN) HISPANIC OR LATINO?  Yes, Hispanic or Latino     No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):

- American Indian or Alaska Native     Black or African American     White     Asian     Native Hawaiian or Other Pacific Islander

**ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)**

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# or check "None" if you do not have a SS#.

I CERTIFY that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on this form; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult Household Member _____	Signature Date Mo./Day/Yr. _____	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***_**_ _____ <input type="checkbox"/> None
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**FOR CENTER USE ONLY – All 3 sections and the Effective Date must be completed**

<b>1) Basis of Determining Eligibility</b> <input type="checkbox"/> Total Household Size _____ <input type="checkbox"/> Total Income \$ _____/_____ <input type="checkbox"/> FoodShare WI <input type="checkbox"/> W-2 Cash Benefits <input type="checkbox"/> FDPIR <input type="checkbox"/> Foster Child(ren)	<b>2) Eligibility Determination</b> <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Non-Needy	<b>3) Determining Official's Initials &amp; Approval Date</b> _____ <b>Effective Date of the Determination</b> _____
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Use the following conversion factors to determine yearly income only when multiple pay frequencies are reported: Weekly income x 52 = Yearly income. Every 2 weeks income x 26 = Yearly income. Twice a month income x 24 = Yearly income. Monthly income x 12 = Yearly income.

This form expires one year from the agency's chosen effective date, as indicated in its CACFP online application.



**Parent/Guardian Instructions:**

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child, to meet the annual updating requirements.**

GENERAL INFORMATION		
Child's Name	Child Care Facility	Child's Age

HOURS AND MEALS WHILE IN CARE										
Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tuesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wednesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thursday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information

Signature of Parent/Guardian ➤	Date Signed
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ANNUAL UPDATE 1
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Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➤	Date Signed
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ANNUAL UPDATE 2
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Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➤	Date Signed
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## INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under age 2 in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** This form is to be completed by a parent and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

### PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)

Nickname (If any)

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

**HEALTH** Note: Health conditions that may affect the care of the child must be recorded on the department's form, Health History and Emergency Care Plan. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

### MEALS

Current feeding schedule

Length of time on current schedule

Food type

Formula  Strained  Junior  Table  Milk type – Specify:

New food timetable

When eating, child is –

Held in lap  In highchair  Other – Specify:

Feeds self

Yes  No If "Yes", uses:  Spoon  Fork  Hands

Special feeding problems

Yes  No If "Yes" – Specify:

Food allergies

Yes  No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

**SLEEP**

Current sleep schedule	Length of time on current schedule
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Falls asleep easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Mood upon awakening – Describe.
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Takes favorite toy(s) to bed – **child over age 1 year**  
 Yes  No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**  
**Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. See DCF 250.09(2)(c) and DCF 251.09(2)(bm).  
 Back for children under age 1 year  Side or stomach (physician statement attached)

Sleep position – **child over age 1 year**  
 Back  Side or stomach

UPDATES

**DIAPERING / TOILETING**

Diaper – type <input type="checkbox"/> Cloth <input type="checkbox"/> Disposable	Diapers provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No
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Plastic pants used  
 Always  Never  Sometimes If "Sometimes" – Specify:

Highly sensitive skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diaper rash <input type="checkbox"/> Yes <input type="checkbox"/> No
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Lotions, powders or salves used  
 Yes  No If "Yes", product name(s) – Specify:

Toilet training attempted  
 Yes  No If "Yes", describe routine.

Type of toilet seat used at home  
 Potty chair  Special toilet seat  Regular toilet seat

Regular bowel movements  
 Yes  No How often. Time(s) of day:

Toileting problems  
 Yes  No If "Yes" – Describe.

UPDATES

**VERBAL COMMUNICATION**

Family speaks what language – Specify.  
 English  Other If "Other" – Specify:

Age child began talking	Child speaks in <input type="checkbox"/> Words <input type="checkbox"/> Sentences
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Words used to describe special needs – Specify.

UPDATES

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**COMFORTING**

Does child have a fussy time?

Yes  No If "Yes" – Specify time.

How is fussy time handled?

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Child likes to be:

Held  Sung to  Rocked  Read to  Other – Specify:

Special things you say or do to comfort child.

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UPDATES

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**SELF-EXPRESSION**

What causes your child to feel angry or frustrated?

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What frightens your child and how is it shown?

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How does your child express feelings of happiness, enjoyment, etc.?

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Additional comments

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UPDATES

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**PHYSICAL AND SOCIAL DEVELOPMENT**

Is your child able to – (Check all that apply)

Sit up alone  Pull up  Crawl  Walk holding on  Walk without support

Yes  No Is your child used to playmates?

Comments

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UPDATES

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**MISCELLANEOUS**

Child's **indoor** favorite toys and activities – Specify.

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Child's **outdoor** favorite toys and activities – Specify.

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By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

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UPDATES

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**SIGNATURE** – Parent

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Date Signed

### Infant Meal Notification

<b>Child Care Center Name:</b> Central Clark County Community Child Care Center, 7 C's Daycare
<b>Iron-fortified Infant Formula offered by Center:</b> Prebiotic Advantage (generic Similac Advance)

All children enrolled in this center, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Child care centers in the program are reimbursed to help with the cost of serving nutritious meals to enrolled children. The meals must meet CACFP nutrition guidelines for children and infants. To meet CACFP requirements this center will provide formula and other foods for infants.

To help provide the best nutritional care for your infant, please complete the following information and return it to the center:

<b>Infant's First and Last Name:</b>	<b>Infant's Date of Birth:</b>
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I understand that the child care center will supply the above iron-fortified infant formula for infants according to the CACFP requirements. **\*Note: Child care centers may request parents to supply clean, sanitized, and labeled bottles on a daily basis.**

<b>If you <i>formula-feed</i> your infant, place a check mark (✓) by only ONE of the following:</b> <input type="checkbox"/> I prefer to have the child care center supply formula. OR <input type="checkbox"/> I will supply formula for my infant.
<b>If you <i>breastfeed</i> your infant, place a check mark (✓) by only ONE of the following:</b> <input type="checkbox"/> I will supply expressed (pumped) breastmilk. OR <input type="checkbox"/> I will supply expressed (pumped) breastmilk and have the child care center supply formula to supplement as needed. OR <input type="checkbox"/> I will supply expressed (pumped) breastmilk and will supply formula to supplement as needed.

I understand the child care center will supply infant cereal and other foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements. Infant foods include fruits/vegetables, meat/meat alternates, enriched bread or snack crackers, and 100% full strength juice that are creditable to the USDA Infant Meal Pattern.

<b>Place a check mark (✓) by only ONE of the following:</b> <input type="checkbox"/> I prefer to have the child care center supply infant cereal and infant foods. OR <input type="checkbox"/> I will supply infant cereal and infant foods for my infant.
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**\*\*This facility has not requested or required me to provide infant formula or food for my infant. I understand that I have the choice of having my infant participate in the CACFP.**

\_\_\_\_\_  
**Parent/Guardian Signature** \_\_\_\_\_  
**Date**

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS  
MEDICATION INFORMATION AND AUTHORIZATION**

**A. FACILITY AND CHILD INFORMATION**

Name – Child Care Center

Name – Child

Birthdate (mm/dd/yyyy)

**B. MEDICATION INFORMATION:** Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			

Yes  No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

\_\_\_\_\_  
Name – OTC Medication

\_\_\_\_\_  
Parent Initials

Additional information / special instructions / contraindications – Specify.

**C. AUTHORIZATION**

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

**SIGNATURE** – Parent or Guardian

Date Signed

## ALTERNATE ARRIVAL / RELEASE AGREEMENT – CHILD CARE CENTERS

**Use of form:** This form is voluntary. However, this completed form, when on file in the child's record, meets the requirements of DCF 250.04(6)(a)3. and DCF 251.04(6)(a)5. and 251.095(4)(a)2. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Complete this form for placement in the child's file when the child will arrive at the center from school, home or other activities, or depart from the center to go to school, home or other activities, and the child will not be accompanied by a parent or other previously authorized person or transported by the center. This form should be updated as information changes. Periodic review with the parent / guardian is recommended to ensure safety. If the center transports the child, the department's form "Transportation Permission – Child Care Centers" may be used to obtain parental authorization.

### ARRIVAL INSTRUCTIONS

My child \_\_\_\_\_  
(Child's name)

will arrive at \_\_\_\_\_  
(Name of center)

from \_\_\_\_\_  
(School, home or other activity)

by way of \_\_\_\_\_  
(Walking, bicycle, bus, car pool, etc. Be as specific as possible.)

at \_\_\_\_\_  A.M. OR  P.M.  
(Time of arrival)

on  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  
(Days of the week)

My child will arrive from this destination  with OR  without center supervision.

### RELEASE INSTRUCTIONS

My child \_\_\_\_\_  
(Child's name)

will leave \_\_\_\_\_  
(Name of center)

by way of \_\_\_\_\_  
(Walking, bicycle, bus, car pool, etc. Be as specific as possible.)

to go to \_\_\_\_\_  
(School, home or other activity)

at \_\_\_\_\_  A.M. OR  P.M.  
(Time of departure)

on  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  
(Days of the week)

My child will travel to this destination  with OR  without center supervision.

### ADDITIONAL INSTRUCTIONS

I understand that I am responsible for notifying the center of any changes in this schedule such as vacation, school conference days, etc.

SIGNATURE – Parent

Date Signed (mm/dd/yyyy)