Room For Growing
Educational Child Care

Health Care Summary

(MUST BE COMPLETE BY CHILD'S PHYSICIAN)

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.

Indicate if you or someone else is following the child for the problem, and list what problems require special attention at the center.

Important Health Problems	Followed By You	Followed by other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the group day care center

____

____

____

Source of Health Care (Dr. Signature) Associates or Clinic

Date ______________________

____

Address

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Emergency Information & Consent For Treatment

Date ____
Child's Name ____
Family Name: Mother ___________________________________ Father __________________________________
Home Address: Mother ____
Father ____
Home Phone: Mother ___________________________________ Father ____________________________________
Cell phone ________________________________ Cell phone _________________________________

Mother's Employer ____Cell _______________________
Address ____ Phone _____________________
Father's Employer ____ Cell _______________________
Address ____ Phone _____________________

In An Emergency, Contact:
1. ____ Relationship to Child ________________
Address ____ Phone _____________________________

2. ____ Relationship to Child ________________
Address ____ Phone _____________________________

Who is authorized to call and receive information about your child: ____
____
(child will be released ONLY to individuals indicated above)

Consent For Treatment

This is to certify that from the beginning of enrollment to the end of enrollment I hereby constitute and appoint Room For Growing my true and lawful attorney, and for the purpose of authorizing traumatic emergency medical treatment to, and the performance of any procedure determined to be necessary after consultation on the emergency with the Family Physician of my child.

Child's Name Birth Date Medical Conditions/Allergies Date of Last Tetanus

____
Family Physician ____ Phone __________________________
Address ____
Family Dentist ____ Phone __________________________
Address ____

Signature ____ Relationship to Child _______________________

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Enrollment Application

*Please fill out this application. It is the parent/guardian responsibility to notify us immediately of any changes in employment or residence.

Child Information

Starting Date ________________________________ Days Needed M T W R F Times ______________________

Child's Name (first) ___________________________ (MI)______(last)___________________(DOB)____________

Home Address __________________________________ (City)_________________(State)______(Zip)__________

Parent Information

Who is the child's legal guardian?________________________________ Any special circumstances?_______________
____

Mothers Name _____________________________ (DOB)____________________ SS#_________________________
E-MailAddress _____________________________Home Phone ________________Work Phone __________________
Home Address _____________________________ (City)____________________(State)________(Zip)____________
Mothers Employer __________________________(Location)____

Fathers Name______________________________ (DOB)____________________ SS#_________________________
E-MailAddress _____________________________Home Phone_________________ Work Phone _________________
Home Address______________________________ (City)_____________________(State)______ (Zip)____________
Fathers Employer ___________________________ (Location) ____

In Emergency Contacts – In an emergency we will contact an authorized pick-up (other than yourself) in the event a parent or guardian cannot be reached. The child will be released only to individuals indicated below if we cannot reach you first.

Name ____________________________ Address _______________________Home Telephone___________________
Cell Phone________________________ Work Phone ____________________Relationship to Child_______________
Name ____________________________ Address _______________________Home Telephone___________________
Cell Phone________________________ Work Phone ____________________Relationship to Child_______________

Medical Information

Clinic Name ______________________________________ Location ____
Doctor Name _____________________________________ Phone ____

Dental Clinic ______________________________________ Location ____
Dentist Name _____________________________________ Phone ____

In the event of serious illness or injury, Room For Growing's emergency source is 911. Your child will be taken to the nearest medical facility. Please sign the release below authorizing Room For Growing to act in an emergency or make a decision regarding your child when a parent cannot be reached.

Parent Signature ____ Date _____________________________

Director Signature ____ Date _____________________________

Individual Child Profile

Child's Full Name ____ Birthdate ___________________

Start Date ____

Schedule (Circle Dates) M T W Th F Estimated Drop Off & Pick Up Times ________________

Personal History

What language is spoken in your home? ____

Are there any family traditions, beliefs or information about your heritage that you would like us to address at the center to help your child adjust and feel comfortable? ____

____

Are there any family concerns you think we should be aware of? ____

Health History

What arrangements can you make for your child's care during illness? ____

____

Does your child currently have communicable disease? Yes Or No

If yes, please explain (optional) ____

____

Any serious illness that require hospitalization? ____

Any physical limitations or concerns? ____

Any emotional concerns? ____

Any social concerns? ____

Are there any medications given regularly? ____

Does your child have any dietary needs, restrictions, food allergies or food sensitivities? __________________________

Toilet Habits

Is your child potty trained? ____

Does your child need assistance in the bathroom? ____

Sleeping Habits

How many hours does your child sleep per night? ____

Does your child nap? ____

Additional Information

Please share any additional information that will help your child adjust better in our program. ____________________

____

Parent Tuition Agreement

My child ____is enrolled in the Room for Growing program.

The weekly tuition rate at the start of enrollment is: $ ______________

Initials	Parent Agreement
	Tuition is due on the first day of attendance every week. Room For Growing does not offer free vacation or sick days. Tuition is due whether a child attends or is absent. We do offer one vacation week per year at half cost, after six months of enrollment.
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	If tuition is not paid within three (3) days of that time, **a $25.00 late fee** will be added to your account.
	I understand my rates may change and this amount will be adjusted accordingly. I have read the regulations regarding tuition payments and agree to abide by them.
	All accounts outstanding 30 days or more will be submitted to collections, if not paid.
	I understand that children under the age 4 will not be transported by us. Children over 4 may be transported with written parent permission for each individual trip taken.
	Room For Growing charges $50 deposit to every family to hold your child's spot every summer and fall. This $50 is credited back to your account the first week of the summer program and then again the first week of the fall program.

____ _______________________________

Parent/Guardian Signature Date

____ _______________________________

Parent/Guardian Signature Date

____

Signature of Director

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Room For Growing Facts To Know

(Please read carefully & Sign)

Days Closed: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Day and Good Friday. In addition if a holiday lands on a Saturday we will be closed the Friday before, and if the holiday lands on a Sunday we will be closed the Monday after. We will close early on Christmas Eve (12:30pm) and New Year's Eve (4:30pm).

Fieldtrips: Children under the age of four years will not be transported. Children over four years old will be transported by a bus service with written parent permission for each individual trip taken.

Consent For Release Of Health Information In Accordance With 9503.0125: The information contained in the child's record is collected to assist the license holder in providing appropriate care for the child. It is available to the child, the child's parent or guardian, the child's legal representative, employees of the license holder and the Commissioner of the Minnesota Department of Human Services. With this release, I permit the HEALTH CONSULTANT of the license holder to review health and medical information contained in the child's record in order to identify specific health/medical needs of the child and to recommend program plans to assist the license holder to meet these health/medical needs.

Exclusion Policy: To maintain a healthy environment we follow DHS exclusion policies for illness. Children will be sent home if they have a temperature of 100 degrees or above, diarrhea, vomiting, undiagnosed rash or pink eye. Children must be fever free and medication free for 24 hours, before returning to care. Children must be free of diarrhea and vomiting for a 24 hour period before returning to care. Pink eye must have a full day of treatment before returning to the center.

Medication: We do not administer over the counter medications without a doctor's note. The doctor's note should include the dosage and times to be administered. If your child should need a medication like Tylenol or cold medication while in our care, please make sure that you have a doctor's note along with the medication. Prescription medications can be given without a doctor's note due to the fact that a physician has prescribed them. All medications must come in with the child's first and last name on it and original label intact.

Late Pick-Up: The north and south centers in Forest Lake are open from 6-615pm and the North Branch and Chisago centers are open from 6-630pm. We charge $1 per minute per child past closing that you are late picking up your child.

Babysitting Policy: Room For Growing does not support or endorse families using our staff for the purpose of babysitting their children. Parents are not allowed to solicit staff for babysitting their children while they are working during the day at the center. Nor is staff allowed to solicit families for the purpose of babysitting while they are working. Any activity in reference to babysitting must be done outside of the center.

SUIDS: All infants are placed in the back to sleep position in their cribs while napping at the center. A doctor's note is required to place an infant in any position other than back to sleep. This includes having an infant sleep in an elevated position. Also, all infants will be placed in a sleep sack as an alternative to blankets, while napping in their crib. Blankets are not allowed until a child is one year old.

Parent Signature ____ Date ________________

Post Visit Response Form

We are delighted that you have chosen to visit our early childhood program and hope that you enjoyed your time with us today. In an effort to better understand and serve the needs of the children and families, we ask that you take a few minutes to complete the following thoughts.

During my tour of your center –

I learned . . .

I liked . . .

I wondered . . .

I didn't understand . . .

I felt . . .

I didn't like . . .

I have decided that this program meets the needs of my child and our family because . . .

I have decided that this program does not meet the needs of my child and our family because . .

Name ____

Telephone ____