

**CBSR Early Learning Center**

**3455 South 148th Street, Tukwila, Washington 98168**

**(206) 327-9573**

When registering your child the following information needs to be completed: Child Care Registration Form

Child Care Agreement

Child Care Medication Authorization Form Child Care Medication Log

Individual Care Plan for Child in Child Care Certificate of Immunization Status Sanitizer/Disinfectant Approval Request Child Care Parent/Guardian Permission

When completing this application you must:

* Print clearly in BLUE or BLACK ink.
* Answer all questions and make sure you complete the entire application. Incomplete application will not be accepted. ·
* Provide parent signature where required on all forms.

Once your application is complete and signed, please hand deliver this application to the Church By the Side of the Road Early Learning Center.

Thank you for applying to entrust us with the care of your child(ren). We understand that choosing ones childcare arrangements is not something taken lightly. Therefore, we look forward to the opportunity to prove ourselves in your child's eyes. We also anticipate building a strong, communicative relationship with you through positive daily interactions. If you have any questions or concerns regarding this application process please don't hesitate to ask. Once again, thank you, and have a wonderful and blessed day!

3455 S. 148th St., P.O. Box 68545, Tukwila, WA 98168 ⦁ (206) 327-9573 ⦁ (206)243-5024 ⦁ ELC@cbsr.org ⦁ [www.cbsr.org](http://www.cbsr.org)

|  |  |  |
| --- | --- | --- |
| **CBSR ELC Child Care Registration Form** | Date child entered care | Date child left care |
| Child's name (Last, First, Middle) | ! | Name used (Nickname) |  |  | Birthdate |
| Street address |  | City |  |  | Zip code |
| Child's parent/guardian name | Circle the best number to contact you at when your child is in our care |
| cell phone # | home phone # | alternate phone # |
| Street address |  | City |  |  | Zip code |
| Email  |  |  |  |  |  |
| Child's parent/guardian name | Circle the best number to contact you at when your child is in our care |
| cell phone # | home phone # | alternate phone # |
| Email |  |  |  |
| *I give my permission for any of the fallowing individuals to be contacted and my child may be released to any of them.**Parent/Guardian signature: Date:* |
| **In an emergency, if you are not able to contact me, contact the following:** |  |
| Name (first and last) | cell phone # | home phone # |  | alternative phone # |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| These individuals also have permission to pick up my child: | home phone # | alternative phone # |
| Name (first and last) | cell phone # |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Child's health information |
| Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: Phone:Street Address: | Child's last physical exam, if available |
| Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: Phone:Street Address:  | Child's last dental exam,if available |
| Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.) |

|  |
| --- |
| Consent to medical care and treatment of minor children |
| I give permission that my child, may be given first aid/emergency treatment by the child care licensee and or qualified staff at:Name of Licensee: Address of Licensee: Parent/guardian signature I Date I Parent/guardian signature I Date |
|  |
| When I cannot be contacted, I authorize and consent to medical surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct. |
| Parent/guardian signature | I | Date | I | Parent/guardian signature | I Date |

## CBSR EARLY LEARNING CENTER CHILD CARE AGREEMENT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child's name:** |  | First |  | Middle |  |  | Last |  |  |
| **Parent or Guardian name:** |  | First |  | Middle |  |  | Last |  |  |
|  |
| Days and times my child will receive care: |
| Check days of care | ❑ Sunday | ❑ Monday | ❑ Tuesday | ❑ Wednesday | ❑ Thursday | ❑ Friday | ❑ Saturday |
| Arrival time |  |  |  |  |  |  |  |
| Departure time |  |  |  |  |  |  |  |
|  |
|  FEE:$ per: ❑ Hour* Day
* Week
* Month
 | Date payment due: |
| Source of payment:❑ Parent❑ Other (specify): |
| Overtime rate: $ | per: |  |  | I Late | fee: $ | per: |  |  |  |
|  |
| I **agree to promptly notify the child care provider of any changes of the above information.** I **understand that** I **am fully responsible for the terms of this agreement as stipulated.**I **have read, understand and agree to comply with the policy and procedures and information for parents given to me by:** |
| Name of Licensee |
| Parent or guardian signature Date I Parent or guardian signature Date |
|  |
| I **agree to provide child care services according to the above plan.** I **agree to promptly notify the parents or guardians of any changes** to **above information.** |
| Licensee signature |  |  |  |  |  |  |  | Date |  |
| Street Address |  |  | City |  |  | State |  | Zip code |  |
|  |
| Comments |

**Child Care Medication Authorization Form**

An early learning or school-age provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate cleaned and sanitized medication measuring devices.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child's full name (first and last): |  |  |  | j | Child's Birthdate: |
| Name of Medication (as it appears on medication container): |
| Dosage: | I | Start Date: | I |  | End Date: |
| To be given at the following times: |
| Reason for Giving Medication to Child/Medical Need: |
| Possible Side Effects of Medication: |
| Additional Information: |

**Prescription medication** must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name,. the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

**Non-prescription (over-the-counter) medication** must be brought to the early learning or school-age program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

*I hereby give permission for the staff* of *to give my child the medication as prescribed above. (Name of early learning or school-age provider/program)*

*Parent/Guardian Signature Date*

**This section to be completed by child's parent or guardian, if applicable:**

*I, or my appointed designee, have provided training about specialized medication administration procedures for my child*

*specific to this medication to the following staff member(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent/Guardian (or Designee) Signature Date Early Learning or School Age Provider Signature Date*

**Child Care Medication Log**

|  |
| --- |
| Child's Name (first and last}: |
| Name of Medication (as it is appears on medication container): |
| \*\* **If a medication was not given, you must document the reason why.\*\*** |
| ' .' 'Date ' Time Dosage ' Side Effects Observed (if any}I ''' '' '' ' ' ''**J**Name of person who gave medication:*(print name)* |  |
| *(signature)* |
| Date | .'''' | Time | ''''''' | Dosage | .'''' | Side Effects Observed (if any} |
| Name of person who gave medication:*(print name)* |  |
| *(signature)* |
| Date | ''''' | Time | '''''' | Dosage | ' | Side Effects Observed (if any} |
| ' |  |
| '' |  |
| Name of person who gave medication:*(print name)* |  |
| *(signature)* |
| Date ' Time ' Dosage' ' .' II* **· J**

Name of person who gave medication: | ''''**J**' | Side Effects Observed (if any) |
| *(print name)* | *(signature)* |
| Date Time Dosage ; Side Effects Observed (if any)' i II'' 1'------------------'-----------------··········----------- '-----------------------------················-------·····················----·---Name of person who gave medication: |
| *(print name)* | *(signature)* |
| Date '' Time ' Dosage ''' ' ''' ' '•••• • •• 'I 'I•. •-- 'IName of person who *gave* medication: | * ••.••• •••\_.
 | Side Effects Observed (if any)* .\_ •• \_•• •• .\_. •••••• ••••••\_
 |
| *(print name)* | *(signature)* |
| Date .' Time ' Dosage'' '' '' '**·** 'Name of person who gave medication: | ''' | Side Effects Observed (if any) |
| **J**' |  |
|  | .*(print name)* |  | *(signature)* |
| Date I Time '' Dosage'' ''.'' '''Name of person who gave medication: | ' | Side Effects Observed (if any) |
| ' |  |
| *(print name)* | *(signature)* |

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

|  |  |
| --- | --- |
| Child's Full Name | Today's Date |
| **CONTACT INFORMATION:** |
| Parent's/Guardian's Name | Telephone |
| Parent's/Guardian's Name | Telephone |
| Primary Health Care Provider | Telephone |
| Specialist (if applicable) | Telephone |
| Specialist (if applicable).. | Telephone |
|  **CHILD’S SPECIAL NEEDS** |
| Diagnosis, if known: |
| Known symptoms and triggers: |
| Describe activity, behavioral, or environmental modifications that are needed for the child: |
| Allergies (other than food allergy): |
| For food allergies or special dietary needs due to a health condition - must obtain written instructions from child's health care provider (use page 3 of this form or health care provider's form) |
|  **MEDICATIONS (Medication Authorization Form must be completed for each medication)** |
| List medication to be given at **scheduled times,** and how medication is to be given. |
| List medication to be given during an **emergency,** and how medication is to be given.Describe symptoms that would trigger emergency medication. |
| **EMERGENCY RESPONSE PLAN** |
| List the steps and procedures the early learning or school-age provider should perform during an emergency related to your child's special need. |

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

|  |
| --- |
|  |
| **SUGGESTED TRAINING FOR STAFF** |
| List suggested special skills training/education for the early learning or school-age program staff. |
| **SUPPORTING DOCUMENTATION** |
| Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 and 110-301-0300 requires an early learning or school-age provider to have supporting documentation of the child's special needs provided by the child's licensed or certified:1. Physician or physician's assistant
2. Mental health professional
3. Educational professional
4. Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or
5. Registered nurse or advanced registered nurse practitioner.
 |
| **SIGNATURES** |  | ,, | '· | ., |
|  |  |
| Parent or Guardian Signature | Date |  |  |
| Early Learning or School-Age Provider Signature | Date |  |  |
| Health Care Provider Signature*(recommended)* | Date |  |  |

-v, V·-... V· --.../--. V, V• '\.\_/, V, "'v'- V- v·- '-/ V *'-/·* V· V ·V- v·· v- V• , -- V•.·V *""\,/•* '/•. v-v,.V V 'v v, V "",/ V v·- V• v· V· V'

## < This section to be completed by child's parent or guardian, if applicable: <

< *I hereby give permission for to provide <*

< (name of visiting health professional or specialist) <

< *services to my child at this early learning or school-age program.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent or Guardian Signature Date

# Individual Care Plan for Child in Child Care

*Plan must be updated annually or when there is a change in the child's special need*

## FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS

This page must be completed and signed by the child's health care provider and parent or guardian.

|  |
| --- |
| Child's Full Name: j Today's Date: |
| Food the child must not consume (list each food separately) | Appropriate substitute food(s) |
|  |  |
|  |  |
|  |  |
|  |  |
| Describe allergic reactions and symptoms associated with this child's particular allergies. |
| Describe the treatment plan for the early learning or school-age provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication). |
| Other special dietary requirements due to a health condition. |

Health Care Provider Signature Date

Parent or Guardian Signature Date

**Certificate of Immunization Status (CIS)**

Reviewed by:

Date:

Signed COE on File? o Yes o No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child's Last Name:** | **First Name:** |  | **Middle Initial: Birthdate (MM/DD/YYYY):** |  |
|  |
| I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record. | Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status. |
| X**Parent/Guardian Signature** |  | **Date** | X**Parent/Guardian Signature Required** if **Starting in Conditional Status** | **Date** |

.& Required for School

* Required Child Care/Preschool

Date

I Date

I Date

I Date

I Date

MM/DD/YY MM/DD/YY MM/DD/YY MM/DD/YY

MM/DD/YY MM/DD/YY

I Date

.**Required Vaccines for School or Child Care Entry**

* **⮙** DTaP (Diphtheria, Tetanus, Pertussis)

⮙ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)

* ⮙ DT or Td (Tetanus, Diphtheria)
* ⮙ Hepatitis B
* Hib *(Haemophilus influenzae type* b)
* ⮙ IPV (Polio) (any combination of IPV/OPV)
* ⮙ OPV (Polio)
* .⮙ MMR (Measles, Mumps, Rubella)
* PCV/PPSV (Pneumococcal)
* ⮙ Varicella (Chickenpox)

D History of disease verified by IIS

**Recommended Vaccines (Not Required for School or Child Care Entry)**

Flu (Influenza) Hepatitis A

HPV (Human Papillomavirus)

MCV/MPSV (Meningococcal Disease types A, C, W, Y)

MenB (Meningococcal Disease type B)

Rotavirus

|  |
| --- |
| **Documentation of Disease Immunity (Health care provider use only)** |
| If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be veri- fied by a health care provider.I certify that the child named on this CIS has: ❑ A verified history of varicella (chickenpox) disease.❑ Laboratory evidence of immunity (titer) todisease(s) marked below. |
| ❑ Diphtheria | * Hepatitis A
 | ❑ Hepatitis B |
| ❑ Hib | ❑ Measles | * Mumps
 |
| □ Rubella | * Tetanus
 | * Varicella
 |
| □ Polio (all 3 serotypes must show immunity) |
| ► |
| Licensed Health Care Provider Signature Date |
| ► |
| Printed Name |

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name:\_\_\_\_

\_\_\_\_\_\_\_ Signature: \_\_\_\_\_ Date:

If verified by school or child care staff the medical immunization records must be attached to this document

**Instructions for completing the Certificate of Immunization Status (CIS): Print the form the Immunization Information System (11S) or fill it in by hand.**

### To print with the immunization information filled in:

Ask if your health care provider's office enters immunizations into the WA Immunization Information System Washington' s statewide registry). If they do, ask them to print the CIS from the TIS and your

: child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. lf your provider doesn't use the US, email or call the

* Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

### To fill out the form by hand:

* 1. Print your child's name and birthdate, and sign your name where indicated on page one.
	2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediatix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
	3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.

o If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.

* If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
	1. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
	2. Provide proof of medically verified records, following the guidelines below.

### Acceptable Medical Records

All vaccination records must be medically verified. Examples include:

* + - A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (!IS), MyIR, or another state's IIS.

., A completed hardcopy CIS with a health care provider validation signature.

* + - A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

### Conditional Status

Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to tum in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

**Reference guide for vaccine trade names in alphabetical order** For updated list, visit [https://www.cdc.gov/vaccines/terms/usvaccines.html](http://www.cdc.gov/vaccines/terms/usvaccines.html)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Trade Name** | **Vaccine** | **Trade Name** | **Vaccine** | **Trade Name** | **Vaccine** | **Trade Name** | **Vaccine** | **Trade Name** | **Vaccine** |
| ActHIB | Hib | Fluarix | Flu | Havrix | Hep A | ·Menveo | Meningococcal | Rotarix | Rotavirus (RV1) |
| Adacel | Tdap | Flucelvax | Flu | Hiberix | Rib | Pediarix | DTaP + Hep B + IPV | RotaTeq | Rotavirus (PVS) |
| Afluria | Flu | FluLaval | Flu | HibTITER | Rib | PedvaxHIB | Hib | Tenivac | Td |
| Bexsero | MenB | FluMist | Flu | Ipol | IPV | Pentacel | DTaP + Rib +IPV | Trumenba | MenB |
| Boostrix | Tdap | Fluvirin | Flu | Infanrix | DTaP | Pneumovax | PPSV | Twinrix | Hep A+Hep B |
| Cervarix | 2vHPV | Fluzone | Flu | Kinrix | DTaP +IPV | Prevnar | PCV | Vaqta | Hep A |
| Daptacel | DTaP | Gardasil | 4vHPV | Menactra | MCVorMCV4 | ProQuad | MMR + Varicella | Varivax | Varicella |
| Engerix-B | HepB | Gardasil 9 | 9vHPV | Menomune | MPSV4 | Recombivax HB | HepB |  |  |

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711). **DOH 348-013 November 2019**

**Sanitizer/Disinfectant Approval Request**

**(for family home and center providers)**

|  |
| --- |
| WAC 110 300 0240(2}(f)(i)If an early learning provider uses a product other than bleach, including wipes, to sanitize or disinfect, the product mustbe approved by the department prior to use, |
| Provider Name: j Provider ID #: |
| Mailing Address: City: State: Zip Code: |
| Phone: | Email: |
| **Proposed Sanitizer/Disinfectant Information** |
| Name of product: |
| Manufacturer of product: EPA Registration #:Product must be registered with the U.S. Environmental Protection Agency (EPA) and must be fragrance-free. |
| List the type of surfaces on which this product will be used (i.e., eating and food prep surfaces, floors, toys, bathroom and diapering surfaces, etc.) |
| *If the department approves the use of this product as I've indicated above, I understand that I must follow the requirements of WAC 110-300-0240(2)(f)(i-vi) regarding department-approved sanitizers and disinfectants.* |
| **Signature** | **Print name** | **Date** |

***Submit this completed form, the product label with direction for use, and the safety data sheet {SDS}***

**for your proposed product to:**

Your local DCYF child care licensing office.

**DCYF will return this request to you with the department's decision indicated in the space below.**

**DCYF may rescind its approval at any time.**

**DCYF Use Only**

Provider Case Number:

The use of this product has been:

❑ Approved, of

❑ Approved with these conditions:

❑ Disapproved, because:

**DCYF Signature Title Date**

SANITIZER/DISINFECTANT APPROVAL REQUEST (FH/CTR) DCYF 15-965 (REV. 08/2019) INT/EXT

**Child Care Parent/Guardian Permission**

|  |  |
| --- | --- |
| Child's Name (First Middle Last) | Licensee's Name |
| **Transportation and off-site activity**I give my permission for the licensee or the licensee's staff to take my child: To and/or from school:By a personal vehicle ................................................................................... □ □By riding with my child on public transportation ........................................... □ □By walking with my child............................................................................... □ □On field trips (a written notice about the field trip will be given at least 24 hours before the field trip is taken): By a personal vehicle................................................................................... □ □By riding with my child on public transportation ........................................... □ □By walking with my child............................................................................... □ □On occasional errands:By a personal vehicle ................................................................................... □ □By riding with my child on public transportation ........................................... □ □By walking with my child............................................................................... □ □Other (specify here):By a personal vehicle ................................................................................... □ □By riding with my child on public transportation ........................................... □ □By walking with my child............................................................................... □ □ |
| **Water activities including swimming pools and other bodies of water**I give my permission for the licensee or the licensee's staff to:Take my child swimming or play in a swimming pool or other body of water............  |
| **Bathing**I give my permission for the licensee or the licensee's staff to:Give my child a bath or shower if my child needs to be cleaned after having anaccident such as diarrhea or vomiting ....................................................................... □ □Give my child a bath or shower if my child is enrolled in overnight child care .......... □ □ |

Date

Parent or guardian signature

Date

Parent or guardian signature

*I have reviewed the licensee's written policies and have had the opportunity to* discuss *with the licensee the policies pertaining to the items listed on this permission form.*

□ □

□ □

Take video of my child...............................................................................................

Capture my child's image on surveillance video used at this child care facility ........

□ □

Take photographs of my child....................................................................................

**Yes No**

**Photo, video, or surveillance activity**

I give my permission for the licensee or the licensee's staff to: