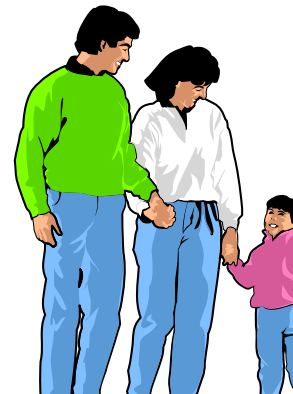


RECORDKEEPING POLICIES AND PROCEDURES FOR YOUR CHILD CARE BUSINESS



Umatilla Morrow
Child Care Resource and Referral
110 NE 4th
Hermiston OR 97838
541-564-6878
1-800-559-5878
www.umchs.org

Acceptance Form

This is to confirm that _____ has been accepted for care at _____ (name of daycare). A place will be reserved until the first day of care which will begin on _____ (date).

An enrollment fee of \$ _____ (equivalent to two weeks of care) has been received. This enrollment fee will not be returned in the event that the child is not placed in care. When the child does begin care, the enrollment fee will be applied to the last two weeks of care.

Date: _____

Signature of parents/guardians: _____

Signature of provider: _____

(Your Business Name and Address Here)

ADMISSION INFORMATION

CHILD'S NAME		BIRTH DATE	AGE
CHILD'S NAME		BIRTH DATE	AGE
CHILD'S NAME		BIRTH DATE	AGE
CHILD'S NAME		BIRTH DATE	AGE
PARENT/GUARDIAN		ADDRESS	HOME PHONE CELL PHONE
PARENT/GUARDIAN		ADDRESS	HOME PHONE CELL PHONE
SOCIAL SECURITY #	SOCIAL SECURITY #		
NAME OF MEDICAL INSURANCE		GROUP #	
PARENT/GUARDIAN CAN BE REACHED AT:			
NAME		ADDRESS	PHONE
RELATIONSHIP		EMPLOYER	PHONE
WORK HOURS FROM: TO:		WORK ADDRESS	
NAME		HOME ADDRESS	PHONE
RELATIONSHIP		EMPLOYER	PHONE
WORK HOURS FROM: TO:		WORK ADDRESS	
IF PARENT/GUARDIAN CANNOT BE REACHED:			
NAME		RELATIONSHIP	PHONE
ADDRESS			
NAME		RELATIONSHIP	PHONE
ADDRESS			
AUTHORIZED TO PICK UP CHILD/CHILDREN BESIDES YOURSELF, <u>WITH A NOTE:</u>		RELATIONSHIP TO CHILD	
NAME			PHONE
NAME			PHONE
NAME			PHONE
<u>SPECIAL ARRANGEMENTS: SCHOOL BUSSING, PICK UP/DROP OFF POINT:</u>		ALLERGIES:	LIKES/DISLIKES, FEARS:
ALTERNATE SCHOOL SCHEDULE:			
<u>NOTES:</u>			

Admission information (continued)

Has your child had previous experience in child care? Yes ___ No ___

Please give any information concerning your child which will be helpful in his/her experience in child care (such as playing, sleeping, or eating habits, fears, likes and dislikes, etc.)

Permission is given to _____ for the following:
(Name of Provider)

My child may be taken on field trips or excursions in a motor vehicle under proper supervision. Yes ___ No ___

Child's Doctor	Address	Phone
----------------	---------	-------

Child's Dentist	Address	Phone
-----------------	---------	-------

Hospital	Address	Phone
----------	---------	-------

Is your child receiving medication? If yes, for what reason?

Medication child is taking for an ongoing condition? Yes ___ No ___

Are your child's immunization up to date for their age? Yes ___ No ___

Has your child had: (Please circle all that apply)

Chicken Pox	Hepatitis	Meningitis	Pertussis(Whooping cough)	Strep Throat
Cold Sores	Impetigo	Mumps	Rubella	Tuberculosis
Head Lice	Measles	Pink Eye	Scabies	Other:

Other serious health problems:

Are the problems serious enough to restrict your child's activities? Yes ___ No ___

Please explain:

In an emergency, _____ has my permission to take my child to an available physician or hospital, at my expense, if I am unavailable. Please initial your intended response: Yes ___ No ___

In an emergency, the above named has my permission to call my listed physician and, if necessary, give consent to a doctor or hospital to administer medical or surgical treatment and care for my child, at my expense, if I am unavailable.

Yes ___ No ___

Name of insurance company: _____

Group Number: _____

In an emergency, my child may receive first aid treatment. Yes ___ No ___

Signature of Parent/Guardian

Date

Medical Emergency Information/Release

As a parent or legal guardian of the following child(ren):

_____ name and date of birth _____ name and date of birth

I hereby authorize

_____ Name of caregiver _____ address _____ phone

Who is 18 years or older, to consent to any medical or surgical treatment of the above named children, which such person deems advisable, if a parent or legal guardian cannot reasonable be located when child/children are brought for treatment.

The above authorization will be effective as of this date _____ until _____.
(Total period by law may not exceed six months)

During this period the parent or legal guardian of the above named child/children will be at the following location: _____ phone: _____

Home address of parent/guardian _____ phone: _____

Employer: _____ phone: _____

If parent or guardian cannot be reached during childcare hours, contact the following persons:

Name: _____ phone: _____

Child's

Physician _____ phone: _____

Health Insurance Company: _____ Number: _____

Chronic illnesses or allergies of the above named children:

Current Medications:

Initial the following boxes for your permission to do the following:

_____ In an emergency, the childcare provider has my permission to call an ambulance or take my child to any available physician or hospital.

_____ In an emergency, the childcare provider has my permission to obtain medical treatment for my child, except for these restrictions.

List: _____

_____ My child may be given prescribed medication.

_____ My child may be given non-prescribed medication.

_____ My child may be taken on field trips by private motor vehicle with required supervision and adequate seatbelts/safety restraint devices.

_____ My child may participate in water activities.

_____ My child may be photographed during in-house activities.

_____ My child may be photographed for publicity purposes. (local paper or newsletter)

Signature: _____ or _____ Date: _____
mother/guardian father/guardian

Medical Form

Basic Information

Date: _____

Name of Child: _____ Birthdate: _____

Mother's name: _____ Home phone: _____ Bus. Phone: _____

Father's name: _____ Home phone: _____ Bus. Phone: _____

Child lives with ___ mother, ___ father, ___ other _____

Other children living with child:

Name: _____ age: _____ sex: _____

Name: _____ age: _____ sex: _____

Name: _____ age: _____ sex: _____

Health History

Check illnesses child has had or has:

<input type="checkbox"/> asthma	<input type="checkbox"/> epilepsy	<input type="checkbox"/> pneumonia	<input type="checkbox"/> strep throat
<input type="checkbox"/> chicken pox	<input type="checkbox"/> measles	<input type="checkbox"/> rheumatism	<input type="checkbox"/> whooping cough
<input type="checkbox"/> diabetes	<input type="checkbox"/> mumps	<input type="checkbox"/> scarlet fever	_____

Allergies (food, drug, bee sting, etc) List type, symptoms, and treatment required

Immunization (Give month and year of most recent shot):

Small pox _____ rubella _____ polio _____

Mumps _____ diphtheria _____ measles _____

Tetanus _____ tuberculosis _____ other _____

Copy of immunization record attached and signed by doctor: ___yes ___no

Date and clinic of last well child exam _____

Does your child have any special needs that require accommodation by the provider? Please list

Does your child have any functional limitations (physical, mental, social, or behavioral)? Please list _____

Does your child have a condition that, according to current medical information, would pose a direct threat to the health or safety of others in the program? ___yes ___no

Developmental Background

Name of previous childcare program attended _____
Does child have any special problems/fears? _____
Child's favorite activities, foods _____
Child's nap pattern _____
Child's favorite toy or blanket _____
Toilet habits _____
Child's eating habits _____
What makes the child frustrated or upset? _____
Family rules that provider should know about? _____
What methods of discipline do you find work best for your child? _____

Medical Emergency Consent

Name of child's doctor or health clinic _____ phone: _____
Medical insurance company _____ policy # _____
Child's hospital _____ phone: _____
Name of child's dentist _____ phone: _____

When there is a medical emergency or when a child needs immediate medical treatment, the provider will take all reasonable steps to see that the children in her/his care receive adequate medical care. When appropriate, the provider will call 911 and the parents. If the parents cannot be reached, the provider will call the persons listed below who are authorized by the parent to give permission for the medical treatment of the child. The following persons are authorized:

Name: _____ phone: _____

Name: _____ phone: _____

If the parents and the authorized person cannot be reached, the provider will call the child's doctor, identified above. If the child must be taken to the hospital, the provider will take the child to the child's hospital identified above. If, under the circumstances, it is more reasonable to bring the child to another hospital, the provider will do so. In a situation where the parents and the persons authorized to give permissions for medical treatment cannot be reached, the parent authorizes the child's doctor to provide the appropriate medical treatment for the child.

Provider's signature _____ date: _____

Mother/guardian's signature _____ date: _____

Father/ guardian's signature _____ date: _____

If the parent or legal guardian is under age 18, a co-signer must sign this agreement.

Co-signer's signature _____ date: _____

Field Trip Permission Form

General Permission Form

Name of Provider _____ may take _____ (name of child) for short walking trips as part of the family childcare program. Also the provider may take the above child in his/her car for field trips. This form will be in effect for one year from date below.

Date _____ Parent signature _____

Address _____ City/State/Zip _____

Specific Permission Form

Name of Provider _____ has my consent to take
_____ (name of child) on the following trip.

Place _____

Date of activity _____

Parent Signature _____ Date _____

Accident Report Form

Name of injured: _____

Date of accident: _____ Time of accident: _____

Describe how and where accident occurred:

Describe injury:

Accident was observed by: _____

Described first aid given and by whom: _____

Did child continue activities? _____

Name of doctor and facility where child was treated: _____

Child transported by whom: _____

How were parents notified: _____ Date: _____ Time: _____

Report submitted by _____ Position: _____

Date of report _____

Parent signature: _____ Date: _____

Policy for Transporting Children

In operating my childcare business, my first responsibility is to assure the health and safety of the children in my care. When parents drop off and pick up their children, I want to be sure their children are transported safely. When a parent transports children under the influence of alcohol or drugs or fails to use an appropriate car seat, it creates an unsafe transportation situation. I will ask the parent not to transport the child and will propose alternatives. If the parent insists on transporting the child, I will immediately call the police and report the unsafe driving situation.

Alternative 1 – I will call an authorized backup who may be able to transport the child in an emergency. The names of backup drivers are:

Name: _____ phone: _____

Name: _____ phone: _____

Alternative 2 – I will call a cab to pick up the child and the parent. The parent will pay the cab fare.

Alternative 3 – If the parent has failed to bring an appropriate car seat for the child, I will ask the parent to drive home without the child and return with an appropriate car seat installed in the car.

Alternative 4 – Other alternatives

If the parent refuses to agree to one of the above options and insists on leaving with the child, I will call the police and report the unsafe driving situation.

Parent's Signature & Date

Providers Signature & Date

4. If the parent/guardian does not notify the provider that the child is sick and not coming before the designated drop-off time, a fee of \$_____ will be charged for the day.
5. Overtime payments are due the same day they occur.
6. A NSF returned check charge will be added to equal the bank fee.

4. Rates Regarding Holidays, Vacations and Other Absences:

1. The following are paid holidays when they fall on a day regularly scheduled for care:

2. Parents will have five (5) sick days and five (5) vacation days per year when childcare daily fees will not be charged. Anything over ten (10) days will be charged at a full day's rate.

3. Charges related to provider's scheduled vacation are: _____

4. Charges related to parent(s)/guardian's scheduled vacation are: _____

The provider and the parent/guardian will each give _____ weeks advance notice of scheduled vacation or other leave.

5. Substitute care arrangements: _____

6. Other:

5. Other Charges:

1. There will be a charge of \$_____ for each breakfast, \$_____ for lunch, and \$_____ for each snack served.

Other: _____

2. There will be an extra charge for the following infant supplies when not provided by the parent(s)/legal guardian: _____
(Diapers, wipes, baby food, formula, etc.)

And for activity fees/expenses for _____
(Field trips, children's classes, materials for special projects, etc.)

3. A reservation fee (deposit) of _____ is required to be paid on _____ which will be applied to the _____ weeks' payment or forfeited if the child does not come for care.

6. During the probationary period of the first two weeks, either the parent/guardian or the provider can terminate the contract and service. Fees will be adjusted accordingly.
7. This contract may be terminated by either parent/guardian or provider by giving _____ weeks written notice in advance of the ending date. Payment by parent/guardian is due for the notice period, whether or not the child is brought to the provider for care. The provider may terminate the contract without giving any notice if the parent/guardian does not make payments when due. Failure by the provider to enforce one or more terms of the contract does not waive the rights of the provider to enforce any other terms of the contract.
8. Provider may transport children to various locations, including school, park, library, field trips, and so forth. All such transportation is part of the service offered by the provider under this contract, and is included in the parent fee.
9. By signing this contract, parent(s)/guardian(s) agree to abide by the written policies of the provider. The provider may amend the policies by giving the parent(s)/guardian(s) a copy of the new or changed policies at least _____ weeks before they go into effect.

Provider's signature: _____ Date _____

Mother/Legal Guardian's signature: _____ Date _____

Father/Legal Guardian's signature: _____ Date _____

Cosigner's signature _____ Date _____

If the parent or legal guardian is under age 18, a co-signer must sign this agreement and act as a guarantor to the contract and agree to be bound by all financial terms.

PROVIDER-PARENT CONTRACT

I agree to enroll my child, _____,
in the _____ Child Care Program, beginning on
_____. I have received and read the attached Child Care Program Policies
and agree to comply with all rules and responsibilities stated in them.

1. Care will normally begin at _____ a.m. / p.m. and end at _____ a.m. /
p.m. on the following days of the week: Sun Mon Tues Wed Thurs Fri Sat

2. Care will include the following meals and snacks: _____

The parent(s) will provide food for the following:

3. The charge for care of the child is \$ _____ per _____. Overtime
charges are \$ _____ pre _____. There will be a charge of
\$ _____ if the child is picked up after _____ a.m. / p.m.

4. Payment to the Provider will be made in the following manner.

By _____ (method of payment).

By _____ (name of person to pay)

On _____ (day of the week or month).

5. Payment obligation is based on the hours you agree to use child care, not on actual hours of
attendance. Payment is due if you have agreed to use a certain block of time whether or not the
child actually attends during those hours.

6. Children may be taken from the day care provider's care only by the person signed below, by persons listed on the Authorization to Leave Care form or under conditions specified on that form.

Parent's or guardian's signature

Date

Parent's or guardian's signature

Date

Provider's signature

Date

PROVIDER-PARENT CONTRACT continued

Attendance- The following holidays will be observed:

Daycare Fees: A one-time non-refundable registration fee of \$ _____ in full at the time of registration is expected. The fee covers art smock, nap mat, blanket and pillow.

\$ _____ a _____ will be billed to you.
Amount hour/day/week/2weeks/month

A full days rate will apply for any care after 4 hours.

\$ _____ will be charged for every 15 minutes past closing time.

Preschool Fees: \$20 yearly art supply fee is due in full at the time of registration and once a year in September thereafter.

A \$100 yearly Preschool Education Learning Materials fee will be charged. This fee can be made in two equal payments of \$50. This will show on your August and January statements. No preschool will be held from June 1 to September 1.

Billing: A statement will be provided every two weeks, with payment due in full on the above designated date(s). Childcare will be suspended for nonpayment until payment is received.

Illness: No medication will be given without a written Medical Form that is filled out and signed by the parent. Children with a fever, green nose, or contagious disease will not be accepted until the condition is gone.

Sick Leave and Vacations: Parents will have five (5) vacation days per year when childcare daily fees will not be charged. Anything over ten (10) days will be charged a full days rate.

Termination of Care: Two weeks notice must be given to the provider should the parent terminate childcare and two weeks notice must be given to the parent should the provider terminate childcare.

Parent/guardian signature

Date

Provider signature

Date

\$ _____ registration fee has been received in full.

Parent – Provider Policy

Date _____

1. This agreement is made between the Parent/Guardian _____ and Provider _____ for the care of _____, (name of Child) at the home of the Provider.

If the parent/guardian has not notified the provider that he or she will be late picking up the child and the provider is unable to continue care, the provider will call one of the authorized persons to come for the child(ren).

2. Persons authorized to pick up the child(ren):
Mother Yes No Father Yes No

Name _____ Relationship _____

Address _____ car/license _____

Home phone _____ Work phone _____

Name _____ Relationship _____

Address _____ car/license _____

Home phone _____ Work phone _____

The provider will allow only persons who have been authorized by the parent/guardian to remove child(ren) from his/her care.

3. Emergency Policy:

For life-threatening emergencies, the provider will: _____

Name of person(s) to call in case of emergency when parent(s) cannot be reached.

Name: _____ phone: _____

Name: _____ phone: _____

4. Substitute Care Arrangements: _____

5. Children with Special Needs

To assure adequate care of _____, the following is agreed upon:

6. Program Policies: The typical activities for the children are:

Indoor: _____

Outdoor: _____

7. The infant schedule/activities will be: _____

To insure optimal health and welfare of the child(ren), the parent(s)/legal guardian and provider will use the following methods to communicate concerns of the child(ren)'s progress (keep a notebook of daily happenings, talk on the phone once a week, quarterly conferences, etc.) _____

8. Meals, Naps, Extra Clothing, and Toilet Learning:

The following meals and/or snacks will be provided by the provider: _____

Other food information: _____

Nap and rest policy will be: _____

The following items of extra clothing will be provided by the parent(s)/legal guardian: _____

cloth diapers _____ disposable diapers will be provided by _____

For toilet learning the parent/legal guardian will supply (training pants, extra clothes): _____

Potty chair will be provided by parent/legal guardian or provider: _____

9. The provider will hand out a monthly newsletter that will inform parents of upcoming events: birthday parties, library trips, and other special days at the daycare. Parent/Provider conferences will be scheduled every three months or at a schedule convenient to the parents.

10. Discipline Policy: Provider rules for disciplining children will be: _____

11. Other issues: Other issues of concern to either parent/legal guardian or provider: _____

Sick Child Exclusion Policy

Even with the best prevention practices, germs are sometimes shared and children get sick. It is best to be prepared. Excluding a sick child may be the best way to prevent spreading germs. If the child has the following symptoms, it is best for them to stay home.

Please do not bring your children with the following symptoms. They are likely to be contagious and will be kept out of childcare.

1. The child has diarrhea or watery stools.
2. The child has a fever over 100° F.
3. The child has head lice.
4. The child has stomach pains for two hours or pain with fever or pain with other symptoms.
5. The child has vomited two or more times.
6. The child has a body rash with fever, itching, or sores.
7. The child has an eye infection with thick mucus or pus draining from the eye and the white part of the eye looks pink or red.
8. The child has mouth sores with drooling.
9. The child complains of a sore throat and has a fever with swollen glands in the neck.
10. The child appears sick—unusually tired, pale, not hungry, hard to wake up, confused or irritable, or not able to participate in activities.

If a child has or develops any of the above symptoms, the parent will be called at work to pick them up. It is recommended that parents seek advice from their health care provider if these symptoms are present.

Colds are common in children. Excluding children from childcare once they are sick is too late to prevent the spread of the virus. Children who have mild cold symptoms and who do not have any of the symptoms described above do not need to stay out of childcare. Ear infections cannot be spread from child to child. The decision to keep a child with an ear infection in care depends on his/her comfort and needs.

I have read and will follow the sick child exclusion policy.

Parent's Signature: _____ Date: _____

Termination Notice

This note is to let you know that I will not be able to offer my childcare services to

_____ (child's name) beginning on _____ (date).

I will continue to provide my regular childcare services until this date. According to our written contract, you are required to pay for my services up until this date, whether or not your child is present. Your enrollment fee will be used for these last two weeks.

Provider signature: _____ Date: _____

Parent signature: _____ Date: _____

Child Care Fee Agreement

I, _____ agree to pay _____
(Parent/Guardian name) (amount)

per _____ to _____ for child care
(week, month, day) (Provider=s name)

as shown on the schedule below. I understand and agree to pay an additional overtime charge of _____ in the event the child/children are cared for at times in addition to those
(amount per hour)

shown below on the schedule.

Child Care Schedule:

Days of the Week my child(ren) will attend:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Hours of the Day:

Fom: _____ To:

From: _____ To:

From: _____ To:

Number of children that will be in care: _____

Names of children in care:

Meals expected:

Breakfast Snack Lunch Snack Dinner Snack

GI will provide meals for my child

(If I provide meals, I know I must provide nutritious meals and snacks)

Notes:

Parent/Guardian Signature & Date

Provider=s Signature & Date

After Hours Late Fee Receipt

Date: _____
Time of Pick-Up: _____
Parents Name: _____
Child(ren) Name: _____
Late Fees \$ _____ Rate \$ _____
Other Fees \$ _____ For: _____
Amount Due \$ _____
Staff Signature: _____ Parent Signature: _____

Daily Diaper Log / Activities

Child's Name: _____ Date: _____

Diaper Changes	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm

D = dry BM = bowel movement W = wet T = toilet

Time slept: _____ to _____

Activities: _____

Your Child needs: _____ diapers _____ wipes _____ change of clothes _____ other _____

OUCH REPORT!

CHILD'S NAME _____ **DATE** _____

It happened _____ inside _____ outside _____ time of day _____

Brief description of Injury _____

First Aid _____ washed _____ band aid _____ ice _____ rest/observation _____ TLC _____

Person attending the Injury _____ other witness _____

Provider _____ Additional Comments _____

Receipt for Payment Form

Business Receipt for Child Care Services

Date Received _____

Received from _____ \$ _____

Written amount _____

For child care services from _____ (date) to _____ (date)

___ Cash ___ Check number _____

Provider's signature _____

Parent's signature _____

1001

GLORIA'S DAY CARE
DAY CARE * NITE CARE * WEE CARE
215 SOUTH CLARK STREET
CENTREVILLE, MICHIGAN 49032
PHONE: (800) 624-2887

Date _____

Received from _____

_____ Dollars \$ _____

Child's Name: _____

Amount of Account \$ _____

Amount Paid \$ _____

Balance Due \$ _____

Cash ___ Check ___ Other _____

GLORIA'S DAY CARE
TAX ID #123-45-6789

THANK YOU!

By _____

Sample Daily Schedule

8:15 a.m.- breakfast, if the child arrives before this time.

8:45 a.m. - breakfast cleanup.

9 a.m. to 9:30 a.m. - discovery time, children can play on their own or in small groups.

9:30 a.m. to 10 a.m. - story time.

10 a.m. - morning snack.

10:30 – 12 p.m. - young children will take their naps while the older children go outside to play, weather permitting.

12 p.m. - lunch and clean-up.

12:45 p.m. – we walk the kindergarten children to the bus.

1 p.m. - learning session involving art, music, or dance.

2 p.m. - afternoon naps and the older children go out to play.

3:30 p.m. we welcome the kindergarten children back and have our afternoon snack.

5 p.m. - clean-up and quiet time.

