Kat's Little Angels

Enrollment Packet

Please Fill out everything, if it does not apply please put N/A.

KAT'S Little Angels Daycare

Updated 4/9/2021

CHILDREN'S ENROLLMENT FORM

Entrance Date: _____ **Withdrawal Date:** _____

Shift: _____ **Days** _____ **Times** _____

Child's Name: _____ Date of birth: _____ Sex: (M/F) Age: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Father's Information

Father's Name: _____ Email Address _____
Social Security # _____ Home Phone Number: _____
Home Address(if different from child): _____
City: _____ State: _____ Zip: _____

Place of Employment: _____ Work Phone: _____
Employer's Street Address: _____
City: _____ State: _____ Zip: _____

Mother's Information

Mother's Name: _____ Email Address: _____
Social Security # _____ Home Phone Number: _____
Home Address(if different from child): _____
City: _____ State: _____ Zip: _____

Place of Employment: _____ Work Phone: _____
Employer's Street Address: _____
City: _____ State: _____ Zip: _____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) other

The child may be released to the person(s) signing this agreement or to the following:

Name: _____ Address: _____
Telephone Number: _____
Relationship to child: _____ Relationship to Parent(s) or Guardian: _____
Other identifying information (if any): _____

Name: _____ Address: _____

Telephone Number: _____
Relationship to child: _____ Relationship to Parent(s) or Guardian: _____
Other identifying information (if any): _____

Persons to contact in the case of emergency when parent or guardian cannot be reached (If person can pick up child please place a * by name):

*Name: _____ Telephone Number: _____ __
*Name: _____ Telephone Number: _____ __
*Name: _____ Telephone Number: _____ __

Name of Public or Private School child attends, if any:

_____

Child's doctor or clinic name:

_____

Doctor/clinic Contact Number: _____

My child has the following special needs:

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at
the center:

_____

__

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre- existing illness, allergies, or health concerns:

_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ (Birthdate) _____ suffer an injury or illness while in the care of (Facility name) **Kat's Little Angels Daycare** and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian Signature: _____ **Date:** _____

Facility Administrator Signature: _____ **Date:** _____

CHILDREN'S ENROLLMENT FORM

Parental Agreements with Child Care Facility

Kat's Little Angels agrees to provide child care for (Child's Name)_____ On Monday- Sunday from 6:00am. to 11:59pm. from January to December.

My child will participate in the following meal plan (circle applicable meals and snacks)

Breakfast Morning Snack Lunch Afternoon Snack Evening Snack Dinner Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adversary actions to medications, etc., which include my child. **Kat's Little Angels Daycare** reserve the right to terminate service for anyone that is three years of ages or older who is not fully potty trained.

The **Kat's Little Angels Daycare** agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities so curing in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available. I have received a copy and agree to abide by the policies and procedures for **Kat's Little Angels.**

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signature: _____ **Date:** _____

Facility Administrator Signature: _____ **Date:** _____

Safe Sleep Practices Policy

Child's Name: _____ Date of birth: _____

Parent/Guardian Name: _____

Safe Sleep Practices/Policies:

1. Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.
2. Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.
3. No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
4. No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.
5. Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.
6. Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice: Bedding for cots/mats will be laundered daily.
7. Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.
8. Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
9. Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

Kat's Little Angels

Transportation Agreement

This is to certify that I give **Kat's Little Angels** Permission to transport my child_____

from (pick-up location)_____ at _____(am/pm)

to (drop off location) _____ at _____(am/pm).

My child will be transported from _____at _____(am/pm)
Pick up Location

to _____ at _____(am/pm)
Delivery Location

on the following days:
□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

_____ is authorized to receive my child. In the event the authorized Name of Authorized Person
person is not presented to receive my child; the following procedures are to be followed:

_____

_____

The _____is approximately _____ miles from the center.
Location

In the event that my child is not to be transported as outlined above, I agree to notify the ***Kat's Little Angels***.
Facility

Signature (Parent/Guardian) _____ Date _____

Kat's Little Angels

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if **Kat's Little Angels** cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

INFANT FEEDING PLAN

Child's Full Name _____ Date _____

Date of Birth _____

Does the child take a bottle?	Yes [ ]	No [ ]
Is the bottle warmed?	Yes [ ]	No [ ]
Does the child hold own bottle?	Yes [ ]	No [ ]
Can the child feed self?	Yes [ ]	No [ ]

Does the child eat: (check all that apply)

Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used, if applicable?_____

Amount and time of formula/breast milk to be given?_____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: _____

The child has reached the following developmental skills:

Can hold his/her head steady?	Yes [ ]	No [ ]
Opens mouth/leans forward in anticipation of food offered?	Yes [ ]	No [ ]
Closes lips around a spoon?	Yes [ ]	No [ ]
Transfers food from front of the tongue to the back and swallows?	Yes [ ]	No [ ]

Instructions for the introduction of solid foods _____

_____

Food likes _____

Food dislikes _____

Allergies? (including any premixed formula)_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

PARENT'S SIGNATURE: _____ Date: _____

Permission to Photograph

I, _____, give permission for ___Kat's Little Angels Daycare_ to photograph my child,
(Parent or Guardian name) (Child Care Provider)

_____, for the following purposes:
(Child's name)

Type of Use:	(Please check one)	
	Grant Permission	Decline Permission
Still Photographs:		
Display in my personal scrapbook		
Give photographs possibly containing your child to current clients		
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on child care website*		
Post photos on child care's Facebook page		
Other:		
Videos:		
Give video to current parents		
YouTube™ promotional video		
Other:		
Other (please list):		

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

_____ _____
(Parent or Guardian signature) (Date)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give **Kat's Little Angels** , permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes
_____ Band-aids
_____ Neosporin or similar ointment
_____ Bactine or similar first aid spray
_____ Sunscreen
_____ Insect Repellent
_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
_____ Baby Powder
Other (please specify) _____

_____ _____
Parent/Guardian Signature Date

*center should maintain in child's file

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

Parents or Guardian's
Notice of No Liability Insurance and Acknowledgement

I understand that I am being informed in writing by signing this acknowledgement that this facility, Kats Little Angels, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____ _____
Parents or Guardian's Signatures **Date**

_____ _____
Parent or Guardian (Print Names) **Date**

Kathy Bliga _____
Center Director's Signature **Date**

KAT'S

Little Angels

Daycare

Supply List

☐ Face Mask (3 & up)
☐Prepared bottles
☐Pacifiers
☐Diapers
☐Wipes
☐Diaper ointment
☐Extra Clothes (uniforms- black or sky or navy-blue shirt "solid color" & Khaki or Black Pants)
☐Extra formula (ready-made formula for emergency use only, we cannot mix formula)
☐Diaper bag (enough space to store empty bottles and clothes that may be sent home)

Please Remember:

- Please label all items with child's first and last name.
- All creams and sunscreens to be applied require a completed medical authorization form and must be kept in their original containers with your child's full name on it.
- All prescriptions must be in the original containers with the patient's name, dosage and prescribed time to be given. The doctor must complete a medical form before medication can be administered.
- Any over the counter medications (Tylenol, Motrin, etc.) require a permission form from your doctor which must include the proper dosage for your child's weight, age, and the reason why it is to be administered. This medication cannot be given no more than two weeks.

Holidays that will be treated like a weekend

Kat's Little Angels will be open for business on the following holidays but its will be treated as a weekend.

New Year's Day

Martin Luther King Day

Good Friday

Memorial Day

Independence Day

Labor Day

Thanksgiving Day & the Friday after

Christmas Day

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial) Birthdate(s)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? $_____/_____

B. Other Household Members[1]. List all household members (including yourself) not listed in Part I even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How Often	3. Social Security, pensions, retirement / How Often	4. All other income / How Often
1._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Circle the meals your child will normally receive while in care: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X _____ Print Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: check (✓) if applicable ☐ Eligibility: check (✓) one Free ☐ Reduced ☐ Paid-Denied ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow Up Official's Signature: _____ Date: _____