**General Information**

**Hours**

6:00am to 5:30 pm – Monday through Friday

**Ages**

6 weeks to Kindergarten

**Holidays**

January 1st New Year’s Day

May Memorial Day

July 4th Independence Day

September Labor Day

November Thanksgiving Day

November Friday after Thanksgiving

December 24th Christmas Eve

December 25th Christmas Day

*If a holiday falls on a weekend Kiddy Korner will close the following Monday in observance of the holiday.*

Dear Parents:

Thank you for your interest in Kiddy Korner Childcare Center.

The following paperwork must be completely filled out and signed before your child may be enrolled. All information must be completed, if there is something that does not apply to your child please enter N/A (not applicable). Registration fees are due upon enrollment and every anniversary date of your enrollment thereafter. Thank you for your cooperation.

We look forward to seeing you and your child at Kiddy Korner Childcare Center. If you have any questions, please feel free to give us a call.

Thank you,

Kiddy Korner Childcare Center

**REGISTRATION FORM**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_

|  |  |
| --- | --- |
| Mother’s Name: | Father’s Name |
| Address: | Address: |
| Home # Work #  Cell # | Home # Work #  Cell # |
| Place of Employment | Place of Employment |
| Parents Living Together? Yes\_\_\_\_\_ Separated\_\_\_\_\_ Divorced \_\_\_\_\_\_ | |

**Other than you, who is authorized to pick up your child? – Address and phone number required.**

|  |  |
| --- | --- |
| Name: | Relationship to child: |
| Address: | Phone:  Cell: |
| Name: | Relationship to child: |
| Address: | Phone:  Cell: |
| Name: | Relationship to child: |
| Address: | Phone:  Cell: |

Other people to be notified in case of an emergency? – At least one contact is required.

|  |  |
| --- | --- |
| Name: | Relationship to child: |
| Address: | Phone:  Cell: |
| Name: | Relationship to child: |
| Address: | Phone:  Cell: |

**Social Information**

Has your child ever been in daycare before? \_\_\_\_ Does your child require a nap/rest? \_\_\_\_

List all other children in family (name, age, sex) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s favorite toy/activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s method of discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide us with other information which might help us care for your child such as play, eating habits, fears, likes/dislikes, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY FORM**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_

**Family History**

|  |  |
| --- | --- |
| Mother’s Age: | Father’s Age: |
| Brother’s Ages: | Health: |
| Sister’s Ages: | Health: |

**Check if any family members have had, and indicate which members:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies (what kind) |  | Diabetes |  | Tuberculosis |
|  | Arthritis |  | Epilepsy (seizures) |  | Ulcer |
|  | Bleeding Disorder |  | Heart Disease |  | Other (describe) |
|  | Cancer |  | High Blood Pressure |  |  |

**Child’s History**

|  |  |
| --- | --- |
| Position in family (1st 2nd 3rd etc)? | Birth Weight: lbs. oz. |
| Length of Pregnancy: Months | Normal delivery: \_\_\_Yes \_\_\_ No |
| Mother’s health during pregnancy? | Baby’s health after delivery? |

At what age did your child:

|  |  |
| --- | --- |
| Sit alone without support? | Talk (understandable words)? |
| Stand alone? | Toilet trained (day)? |
| Walk? | Toilet trained (night)? |

**Please check the illnesses or problems your child has or has had:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies (what kind) |  | Eczema |  | Rubella (3 day measles) |
|  | Anemia |  | Measles |  | Seizures |
|  | Asthma |  | Medication Reactions |  | Strip Throat |
|  | Chicken Pox |  | Mumps |  | Tonsillitis |
|  | Ear Problems |  | Pneumonia |  | Other |

Does your child take any medication routinely or for a reoccurring problem? Is so, What?

For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any concerns about your child’s:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Behavior |  | Eating |  | Sleeping |
|  | Coordination |  | Elimination |  | Other |
|  | Development |  | Hearing/Vision |  |  |

**Health Care:**

|  |  |
| --- | --- |
| Last Physical exam? | Clinic/Doctor’s Name |
| Clinic/Doctor Address: | Clinic/Doctor Phone # |
| Last Dental exam? | Clinic/Dentist Name |
| Clinic/Dentist Address: | Clinic/Doctor Phone # |

Signature Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CONSENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and consent to emergency medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, such in the interest of my child’s health and well-being, and it is not advisable to take time to notify me in advance.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results, possible alternatives, and the risks, complications, and the anticipated benefits resulting from the proposed treatment and the alternative forms of treatment, including non-treatment.

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

Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information of Child**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Allergies: | Date of last Tetanus Immunization |
| Medications for Allergies: |  |
| Chronic Illnesses: | Other Pertinent Dates: |

**Information on Parent/Guardian**

|  |  |
| --- | --- |
| Name: | Address |
| Cell Phone | Work Phone |
| Home Phone | Physician’s Phone |
| Insurance Company | Policy Number |
| Emergency Contact | Emergency Phone |

**Payment Agreement**

Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WSDL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days Receiving Care (a minimum of 3 days)

M \_\_\_\_\_\_ T \_\_\_\_\_\_ W\_\_\_\_\_\_ Th\_\_\_\_\_\_ F\_\_\_\_\_\_

Agreed arrival and departure time (within 10 hours)

From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I agree to the tuition of \_\_\_\_\_\_\_\_\_\_\_\_ due on the Friday before the 2 week period, including holidays.
* Registration Fee $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Received* \_\_\_\_\_
* Full tuition is due regardless of hours of attendance
* Registration fees are due upon enrollment and every anniversary date of your enrollment thereafter.
* There will be a $25.00 late fee and $1.00 per day thereafter for tuition not paid as agreed. There will be 1% interest charge on accounts not paid in full by the end of the month and at that time the account will go into collections resulting in disenrollment of child.
* There will be a $25.00 charge for all returned NSF checks.
* One week tuition will be waived for vacation when given 2 weeks’ notice for fulltime children per parent handbook.
* There will be a flat rate fee of $1.00 per minute of children not picked up on time as agreed.
* Kiddy Korner may terminate this agreement with a 2 week notice.
* I agree to give at least a 2 week notice of termination of this agreement, withdraw from care, change of hours or days. I understand that I am fully responsible for the terms of this agreement.

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FIELD TRIP PERMISSION SLIP**

My child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has my permission to attend all field trips that his/her class attends. I also understand that notices will always be posted giving dates and times and my required signature.

Signature Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**KIDDY KORNER CHILDCARE CENTER**

1188 Village Way, Monroe, WA. 98272

360-794-1976

I have read and fully understand the Parent Handbook and the Policies and Procedures of Kiddy Korner Childcare Center.

I also have been informed where Kiddy Korner Childcare Center Disaster Plan is located for me to read.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

DSHS Payment Agreement

The Department of Social and Health services requires that families follow the “parent responsibility” stated in the Child Care Subsidies Guide (Please see attached document)

In the incident that DSHS does not cover part or all of your childcare expenses it will be your responsibility to pay for those days.

By signing this form you are stating that you understand all payments are due by the 15th of each month, and agree to pay for any overpayment days that DSHS does not cover.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature & Date