Schedule Contract

Summer Program begins mid June-late August
School Year Program begins immediately following Summer Program

Child's Name_____ Birthdate _____

I request my child to attend Children's Community Center in accordance with the following contracted/scheduled times. **Any changes to this schedule will need approval from the Administrative Team and may incur charges per the Fiscal Policies.**

MONDAY	FROM:	TO:
TUESDAY	FROM:	TO:
WEDNESDAY	FROM:	TO:
THURSDAY	FROM:	TO:
FRIDAY	FROM:	TO:

Classroom # _____ Home School District _____

I have received, read, and understand the **FISCAL POLICIES** of Children's Community Center and agree to be bound by the policies therein.

SIGNATURE:_____ DATE: _____

SOCIAL MEDIA PHOTO RELEASE PERMISSION

CCC has a Website and Facebook Page. Please indicate permission for your child's photo to be included in public posts to these Social Media pages. If you decline photo release permission, your child will not be shown in any public postings.

Yes____ No____

Photo Release Permission

We rely on Email for billing and communication purposes. Please PRINT your Email address below.

Mother's Email_____

Father's Email_____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child.		
☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Diabetes
☐ Gastrointestinal or feeding concerns, including special diet and supplements
☐ Cerebral palsy / motor disorder
☐ Epilepsy / seizure disorder
☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies -- Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian — Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4. and DCF 251.04(6)(a)8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

Sleep Space Release

State regulations require a child be placed to sleep on their back in a crib. If you desire your child to sleep in a location other than a crib (swing, bouncy seat, car seat) please take this form to your physician for medical approval. CCC requires this form be completed and returned prior to enrollment.

Child's Name_____ Date of Birth_____

☐ **YES** I permit my child to sleep in an alternate location such as a swing, bouncy seat or car seat.

Parent Signature_____ Date_____

Physician's Signature_____ Date_____

☐ **NO** my child's only sleep space will be a crib. If my child falls asleep in a swing, bouncy seat or car seat, they must be placed in a crib.

Parent Signature_____ Date_____

Revised 2/2018

INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)	Nickname (If any)	Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)	Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH Note: Health conditions that may affect the care of the child must be recorded on the department's form, *Health History and Emergency Care Plan.* The form should be shared with any person who provides care for the child.

☐ Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule	Length of time on current schedule

Food type

☐ Breast milk ☐ Formula ☐ Strained ☐ Junior ☐ Table ☐ Milk type – Specify:

New food timetable

When eating, child is –

☐ Held in lap ☐ In highchair ☐ Other – Specify:

Feeds self

☐ Yes ☐ No If "Yes", uses: ☐ Spoon ☐ Fork ☐ Hands

Special feeding problems

☐ Yes ☐ No If "Yes" – Specify:

Food allergies

☐ Yes ☐ No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule | Length of time on current schedule

Falls asleep easily ☐ Yes ☐ No | Mood upon awakening – Describe.

Takes favorite toy(s) to bed – **child over age 1 year**
☐ Yes ☐ No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**
Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.
☐ Back for children under age 1 year ☐ Side or stomach (physician statement attached)

Sleep position – **child age 1 year and older**
☐ Back ☐ Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type
☐ Cloth ☐ Disposable

Diapers provided by parent
☐ Yes ☐ No

Plastic pants used
☐ Always ☐ Never ☐ Sometimes If "Sometimes" – Specify:

Highly sensitive skin
☐ Yes ☐ No

Frequent diaper rash
☐ Yes ☐ No

Lotions, powders, or salves used
☐ Yes ☐ No If "Yes", product name(s) – Specify:

Toilet training attempted
☐ Yes ☐ No If "Yes", describe routine.

Type of toilet seat used at home
☐ Potty chair ☐ Special toilet seat ☐ Regular toilet seat

Regular bowel movements
☐ Yes ☐ No How often: Time(s) of day:

Toileting problems
☐ Yes ☐ No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family's spoken language.
☐ English ☐ Spanish ☐ Other If "Other" – Specify:

Age child began talking

Child speaks in
☐ Words ☐ Sentences

Words used to describe special needs – Specify.

UPDATES

COMFORTING

Does child have a fussy time?

☐ Yes ☐ No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

☐ Held ☐ Sung to ☐ Rocked ☐ Read to ☐ Other – Specify:

Special things you say or do to comfort child.

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

☐ Sit up alone ☐ Pull up ☐ Crawl ☐ Walk holding on ☐ Walk without support

☐ Yes ☐ No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's favorite **indoor** toys and activities – Specify.

Child's favorite **outdoor** toys and activities – Specify.

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed

Food Allergy Action Plan

Student's Name: _____ **D.O.B:** _____ **Teacher:** _____

Place Child's Picture Here

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:**	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	_____	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

To be determined by physician authorizing treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
MEDICATION INFORMATION AND AUTHORIZATION

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Name – Child	Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes," I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication _____ Parent Initials _____

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian	Date Signed

ITEMS YOUR CHILD WILL NEED

Infants

- Diapers, Wipes, Ointments
- Pack & Play sized sheet, swaddle blanket or sleep sack (no blankets if under one year of age except single-layer receiving)
- Pacifier, if used
- Food and/or Formula
- Two changes of clothing, seasonally appropriate

Toddlers & Two's

- Diapers, Wipes, Ointments
- Underwear or Pull Ups if toilet training
- Change of clothing including socks LABELED
- Seasonal outerwear
- Shoes with closed toes for running and climbing
- If extended care, cold lunch from home or hot lunch
- If napping, crib-sized sheet and blanket

3K & 4K

- Change of clothing including socks LABELED
- Seasonal outerwear
- Shoes with closed toes for running and climbing
- If extended care, cold lunch from home or hot lunch
- If napping, flat twin-size sheet and blanket

Illnesses

Children brought to CCC with moderate illnesses (runny noses, coughs, low-grade temperatures under 101) will be monitored by staff. If your child is not doing well in the group setting, we may request they be picked up.

Conditions requiring pick-up include...

- Temperatures at or above 101
- Two or more diarrhea
- Vomiting
- Rashes

Children must be symptom free without medication for 24 hours before returning to the center.

Pick Up Procedures

- Please inform a teacher when picking up your child. Accompany your child in the hallways and parking lot.
- Whenever someone else will be picking up your child we must be notified PRIOR to pick up time.
- All authorized persons must be listed on your enrollment documents and provide identification to staff at pick up time.
- Keep your vital information up to date with any change of address, phone number, or emergency contact.
- PLEASE DO NOT ALLOW YOUR CHILD TO PUSH THE HANDICAP BUTTONS IN THE FOYER

Revised 5.10.18