



ENROLLMENT APPLICATION

1. _____ Enrollment fee is \$100 per student, a one-time fee, not part of tuition.
2. _____ Fee is not refundable unless a position is not available.
3. _____ This application is valid when accompanied by \$100 enrollment fee.
4. _____ Once tuition has been paid, a slot will be held for the student.

Child's Name: _____ Birthdate: _____ - _____ - _____

Child's Name: _____ Birthdate: _____ - _____ - _____

Guardian's Name: _____ Referred From: _____

Address: _____ Zip: _____

Email: _____ Phone: _____

Cell Carrier: _____

Monday: _____ - _____

Tuesday: _____ - _____

Wednesday: _____ - _____

Thursday: _____ - _____

Friday: _____ - _____

Requested Start Date: _____ - _____ - _____

Tuition Child 1 \$ _____

Tuition Child 2 \$ _____

Total \$ _____

I/We (parent/guardian) _____, as

Client(s) agree to pay \$ _____ per month to Lil' Sunshine Childcare

for the time in the schedule below for (student) _____

under the terms and conditions specified in the school handbook. Tuition is assessed monthly and must be pre-paid before childcare / preschool begins. Tuition is the same regardless of holidays, closures and absences. Our holiday and closures are listed in the parent handbook and on our website.

Please initial below to accept our terms and policies:

_____ I agree with the handbook rules, holidays, closures, and absence.

_____ I agree to pay the Late Pay charge of \$20 per day, each day my payment is late.

_____ My payment is due on the 1st of this month for next month.

_____ Tuition increase is for January tuition each year.

_____ Notice given this month, makes NEXT month, your last month. Notice is for dropping hours, moving onto kindergarten, or moving out of the area.

_____ Adding hours will mean the new tuition needs to be paid and a new tuition form signed, prior to attending.

_____ Accounts not in good standing will be sent to collection. Client agrees to pay all associated fees with collection or court costs.

_____ Yearly contract renewal on January 1st with 4% increase.

I have understood and agree to abide by the terms of this agreement.

Signature: _____ Date: _____

Date Contacted for Enrollment: _____ Date of Enrollment Meeting: _____

Tuition Paid: _____ Paid by: Cash Check _____ Start Date: _____



Child Enrollment Authorization

Child's Name (Last, First)		Child Nickname
Date of Birth	Date Entered Care	Age at Entry
ALLERGY ALERT Does your child have allergies? ☐ YES ☐ NO If yes, list all allergies on back side of form.		
Parent or Guardian Contact Information		
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Address (Street, City, Zip)	Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Address (Street, City, Zip)	Work Phone
Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Non-Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Medical/Dental Contact Information		
Insurance Provider and Policy Information (if applicable)		
Primary Physician Name		Phone
Dental Provider		Phone
Parent or Guardian Authorization		
Please list any restrictions to permission of the following:		
My child may be taken on field trips or excursions by bus or private motor vehicle, as well as on neighborhood walking excursions under required supervision (see special transportation arrangements section on back of form). ☐ Yes ☐ No		
My child may participate in swimming or other water activities under required supervision (OCC requires approved lifeguard). ☐ Yes ☐ No		
My child may be photographed for publicity or news purposes ☐ Yes ☐ No This applies to ☐ On-site ☐ Off-site photography.		
In an emergency, the child care facility has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.		
Parent/Guardian Signature		Date

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Child Information

Has your child previously been in child care? **No** ☐ **Yes** ☐ If yes, what type of care and for how long?

Reason for requesting care

Child General Information – please include all information that will assist us in providing quality care for your child

Likes and dislikes

Eating habits and schedule

Toileting habits and schedules

Sleeping habits and Schedule

Play

Fears

How your child like does to be comforted when upset?

Child's home language

Special word and their meanings

Are there family cultural backgrounds, traditions, beliefs, or interests that you would like to share with us?

Does your child have any educational special needs (IFSP, etc.) **No** ☐ **Yes** ☐ If yes, List any health partners or providers you would like us to know about.

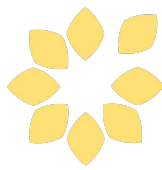
Child Medical Information

Does your child have special medical needs? **No** ☐ **Yes** ☐ If yes, List any health partners or providers you would like us to know about.

Does your child have allergies **No** ☐ **Yes** ☐ If, yes list below **Has your child had chicken pox** **No** ☐ **Yes** ☐

Other Children in the Home

Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender
Name (first, Last)	Age	Gender



TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses child care providers for serving nutritious, well-balanced meals and snacks to children in care. Complete the following chart for all children in care. Sign, date, and return to the center. Use additional forms, as needed. Parents/guardians of all infants must complete the Infant Formula Selection section.

PROVIDER: _____ CHILD START DATE: _____

CHILDREN'S NAMES	NORMAL HOURS IN CARE		Normal Meals and Normal Days in Care
	Enter the time your child usually arrives each day.	Enter the time your child usually leaves each day.	
NAME: _____	_____	_____	Normal Meals While in Care Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
DATE OF BIRTH: _____	Time _____ ☐ AM ☐ PM	Time _____ ☐ AM ☐ PM	Normal Days of the Week in Attendance Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐
NAME: _____	_____	_____	Normal Meals While in Care Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
DATE OF BIRTH: _____	Time _____ ☐ AM ☐ PM	Time _____ ☐ AM ☐ PM	Normal Days of the Week in Attendance Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐

INFANT FORMULA SELECTION:

Complete if any child listed above is an infant under one year of age

This provider offers _____ (list brand) iron fortified infant formula.

Check one:

☐ I accept the provider formula.

☐ I decline the provider formula and understand that by declining the provider formula, I agree to provide breast milk or formula for my child. If I provide formula, it must be on the approved formula list for the provider to be reimbursed for the meal.

Parent Supplied Formula (list brand) or Breast Milk: _____

RACIAL AND ETHNIC INFORMATION (OPTIONAL):

Mark one ethnic identity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Mark one or more racial identities:

☐ Asian

☐ American Indian & Alaskan Native

☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American

☐ White, not of Hispanic Origin

☐ Other: _____

Updates:

(annual at a minimum)

The parent/guardian signing this form certifies that the enrollment form is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initial the change. If there are may changes, please complete a new form.

Parent/Guardian Name (Printed): _____

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

Email Address: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Renewal Date: _____ Parent Signature: _____

Renewal Date: _____ Parent Signature: _____

Renewal Date: _____ Parent Signature: _____



Authorization to Disclose and Receive Medical Records

I _____, provide my authorization to Lil' Sunshine Childcare to discuss my child/ren _____ medical condition with my child/ren physicians and their authorized staff, emergency medical staff, with government agencies as required by law. I also authorize Lil' Sunshine Childcare to release a copy of my child's medical information to those same parties and to receive the same.

Child's Name: _____

Guardian's Name: _____

Guardian's Address: _____

Guardian's Phone Number During the Hours of School: _____

The information is limited and will be used only for the following purpose(s): In the event of injury and emergency care; to discuss a child's illness so that Lil' Sunshine Childcare can determine the health of the child and continued care with Lil' Sunshine Childcare; to ensure that other children are not made ill by an illness of the child named above; and to comply with the required government rules and regulations.

The information is limited and pertains only to medical conditions that pertain to the health of the child while under the care of Lil' Sunshine Childcare and its staff.

By signing I agree to authorize Lil' Sunshine Childcare and its staff to discuss this information with the parties noted above and to receive/release medical information regarding the child's health condition. This authorization may be revoked at any time. The only exception is when the action has been taken in reliance on the authorization.

Signature: _____ Date: _____

Signature: _____ Date: _____



Sunscreen Permission Form

Date: _____

Child's Name: _____

Name of Sunscreen and SPF #: _____

Please apply sunscreen to your child every morning before drop off. As needed throughout the day, your child's care provider will assist with applying sunscreen to bare surfaces including the face, tops of ears and bare shoulders, arms, legs, and feet 15-30 min before outdoor activity. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

Parent Signature

Special Instructions:

_____ I do not want my child to use any sunscreen other than the one that she/he brings.

_____ In the event that my child's sunscreen is not readily available, my child may use the sunscreen provided by the school.

Parent Signature

Oregon Certificate of Immunization Status

Certificado de estado de vacunación

Oregon law requires proof of immunization or exemption signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority.

La ley de Oregon requiere que se entregue un comprobante de vacunación o de exención firmado antes de que un(a) menor asista a la escuela, al preescolar, a un centro de cuidado infantil o a una guardería. Esta información se recopila en nombre de la Autoridad de Salud de Oregon y la escuela o el centro infantil, y puede divulgarse a la Autoridad o al departamento local de salud pública, si la Autoridad la solicita.



Child's last name <i>Apellido del/de la menor</i>	First name <i>Primer nombre</i>	Middle name <i>Segundo nombre</i>	Birth date <i>Fecha de nacimiento</i>
Parents' or Guardians' names <i>Nombre de los padres o tutores</i>		Phone number <i>Número de teléfono</i>	

Write the dates the child received the vaccines

Indique las fechas en las que el/la menor recibió las vacunas

Vaccines / Vacunas	Dose 1 <i>Dosis 1</i>	Dose 2 <i>Dosis 2</i>	Dose 3 <i>Dosis 3</i>	Dose 4 <i>Dosis 4</i>	Dose 5 <i>Dosis 5</i>
Diphtheria/Tetanus/Pertussis <i>Difteria/tétanos/tos ferina</i> (DTaP)					
(Tdap)					
Polio (IPV)					
Varicella (Chickenpox) <i>Varicela</i>			☐ Check if child had chickenpox disease <i>Marque aquí si el/la menor ha tenido varicela.</i> Date / Fecha _____		
Measles/Mumps/Rubella (MMR) <i>Sarampión/paperas/rubéola</i>					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B <i>Tipo B (Hib)</i>					

I certify that the information on the form is an accurate record of this child's immunizations.

Certifico que la información en el formulario es un registro exacto de las vacunas de este(a) menor.

Signature* <i>Firma*</i>		Date <i>Fecha</i>	
Update signature <i>Actualizar la firma</i>		Date <i>Fecha</i>	

* Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations.

** El padre, la madre, el/la tutor(a), un estudiante de por lo menos 15 años de edad, un proveedor médico o un miembro del personal del departamento de salud del condado puede firmar para verificar las vacunas.*

Child's last name <i>Apellido del/de la menor</i>	First name <i>Primer nombre</i>	Middle name <i>Segundo nombre</i>	Birth date <i>Fecha de nacimiento</i>

Other vaccines received <i>Otras vacunas recibidas</i>		Medical exemptions and immunity documentation <i>Documentación sobre las exenciones médicas y documentación de inmunidad.</i>
Vaccine name <i>Nombre de la vacuna</i>	Date <i>Fecha</i>	Medical exemptions and immunity documentation require a letter signed by a licensed physician submitted to your child's school or child care. For the requirements go to www.healthoregon.org/medicalexemptions <i>La documentación sobre las exenciones médicas y documentación de inmunidad exige que se le entregue a la escuela o centro de cuidado infantil de su hijo(a) una carta firmada por un médico autorizado. Para ver los requisitos, visite www.healthoregon.org/medicalexemptions</i>

Nonmedical exemption / *Exención no médica*

I have received information regarding the benefits and risk of immunizations. I understand my child may be excluded from school or child care if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ The vaccine module approved by the Oregon Health Authority
☐ A health care practitioner

He recibido la información relacionada con los beneficios y los riesgos de las vacunas. Entiendo que pueden excluir a mi hijo(a) de la escuela o del centro de cuidado infantil si se presenta un caso de enfermedad que podría prevenirse con una vacuna. Adjunto el documento requerido de parte de (marque una opción):

- ☐ *El módulo de vacunas aprobado por la Autoridad de Salud de Oregon*
☐ *Un proveedor de atención médica*

I request that my child be exempted from the following required immunizations (check all that apply):
Solicito que se exente a mi hijo(a) de las siguientes vacunas requeridas (marque todas las opciones que correspondan):

- ☐ Diphtheria/Tetanus/Pertussis / *Difteria/tétanos/tos ferina*
 ☐ Polio
 ☐ Varicella / *Varicela*
☐ Measles/Mumps/Rubella / *Sarampión/paperas/rubéola*
 ☐ Hepatitis B
 ☐ Hepatitis A
☐ Hib

Optional / *Opciona*

Immunizations are being declined because of:

Se están rechazando las vacunas debido a lo siguiente:

- ☐ Religious belief / *Creencias religiosas*
 ☐ Philosophical belief / *Creencias filosóficas*
☐ Other / *Otro*

Signature <i>Firma</i>		Date <i>Fecha</i>	
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