

# Rockin Round the Clock Child Care Center

## Application, Emergency & Child Release Information

Child's Last Name	Child's First Name	M.I.	Birth Date
Head of Household	Home Phone		Cell Phone
Street Address, PO Box	City	State	Zip Code
Employer's Name	Employer's City	Employer's Phone	
Additional Parent/Guardian	Home Phone	Cell Phone	
Employer's Name	Employer's City	Employer's Phone	

<b>Medical Information</b>		Group #	Primary _____	Secondary _____
MA _____	IM Care _____	ID #	Other Ins. Name	
MN Care _____	Blue Cross _____	Other #		
Physician		Dentist		
Clinic		Clinic		
Address		Address		
City, State, Zip		City, State, Zip		
Phone		Phone		

### Emergency Source of Medical Care:

Hospital	Phone	Address
List any long-term medications your child is currently taking:		
Special Medical Needs:	Special Dietary Needs:	
Conditions we should know about in case of an emergency: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Allergies <input type="checkbox"/> Emotional Disorders	List all allergies:	Describe any condition that is life threatening:

**The signature below gives consent that the child listed above may be released to person(s) listed on this form. Parent or Guardian must authorize person(s) to pick up child/children, a picture ID is also required to remove the child/children from the center. These people will also be considered as Emergency Contacts.**

Name	Relationship to child	Address	Phone
Name	Relationship to child	Address	Phone
Name	Relationship to child	Address	Phone

**Do you have any Order For Protection (OFP) \_\_\_\_\_NO \_\_\_\_\_YES If YES, a copy is required**

I give my permission for one year after date signed to the Rockin Round the Clock Child Care Center Staff to secure needed emergency medical/dental care if parent/guardian or emergency contacts cannot be reached in a emergency. I authorize any licensed practitioner to provide whatever treatment is deemed necessary. I accept responsibility for any costs from treatment.

Parent/Guardian Signature	Date
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## Rockin Round the Clock Child Care Center Medical History Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Address: \_\_\_\_\_  

Street Address, PO Box
City
State
Zip

Hospitalizations and Illness	NO	YES	Currently receiving Treatment	Comments and explanation of "Yes" answers
Did mother have any health concerns during this pregnancy or with delivery? Birth Weight of Child: _____ Height: _____				
Was the child born more than 3 weeks early or more than 3 weeks late?				Early _____ Late _____
Were there any concerns with the child at birth?				
Has the child ever been hospitalized or operated on?				
Has the child had any serious accidents? (head injury, broken bones, falls, burns, poisonings)				
Medical and Dental History	NO	YES	Currently receiving Treatment	Comments and explanation of "Yes" answers
Does your child have frequent: _____ Cough                      _____ Sore Throats _____ Headaches                      _____ Stomach Pains _____ Urinary infections or trouble urinating _____ Vomiting                      _____ Diarrhea				
Does your child have or receive treatment for vision problems? (squints, cross-eyed, holds books to closely)				
Does your child wear glasses?				
Does your child have or receive treatment for ears/hearing? (pain in ear, frequent earaches, ear infections, drainage, hearing loss)				
Does your child have ear tubes?				
Has your child ever had a convulsions or seizures?				
Is your child taking any medications?				Medication Name:
Is a physician or dentist currently treating your child for any conditions?				Name of Physician: Date of Last Exam: Name of Dentist: Date of Last Dental Exam: Physical Condition: Dental condition:
Has your child had any of the following: _____ Chicken Pox                      _____ Eczema _____ German Measles                      _____ Measles _____ Mumps                      _____ Scarlet Fever _____ Whooping Cough                      _____ RSV				Please indicate month and year:
Does your child have or receive treatment for Asthma?				
Do you have an Asthma Action Plan?				Name of Physician: Date of last visit: Medication given:
Have you identified any specific item or circumstances that trigger your child's Asthma?				

Medical and Dental History (continued)	NO	YES	Currently receiving Treatment	Comments and explanation of "Yes" answers
Does your child have or receive treatment for any of the following conditions: <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> High Lead Level <input type="checkbox"/> Overweight <input type="checkbox"/> Liver Disease <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Heart or Blood Disease <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other Conditions?				Name of Physician: Date of Last Visit: Name of Condition:
Are there any foods your child should not eat? For: <input type="checkbox"/> Medical reasons <input type="checkbox"/> Religious reasons <input type="checkbox"/> Personal reasons				All diet requests should include acceptable substitutions. Medical or personal reasons require a special diet form signed by your physician.
Does your child suffer from allergies? (rash, itching, difficulty breathing, sneezing) <input type="checkbox"/> When eating particular foods <input type="checkbox"/> When taking specific medications? <input type="checkbox"/> When near animals, dust, pollen, or insects?				What foods _____ What Medications _____ _____ What other Allergens _____ _____ How does your child react _____ _____ Is a Doctor or Emergency Room visit required? <input type="checkbox"/> NO <input type="checkbox"/> YES
Has your child ever: <input type="checkbox"/> complained of a toothache <input type="checkbox"/> had teeth missing naturally <input type="checkbox"/> had teeth missing from a mouth injury <input type="checkbox"/> received a fluoride treatment <input type="checkbox"/> had bleeding or inflamed gums <input type="checkbox"/> had a cavity <input type="checkbox"/> had a mouth injury Does your child: <input type="checkbox"/> eat sugary snacks <input type="checkbox"/> suck thumb, fingers, or pacifier <input type="checkbox"/> brush his/her own teeth <input type="checkbox"/> have his/her mouth swabbed				
Does your child have a diagnosed disability?				Name of diagnosing agency:
Does your child have a written IFSP or IEP?				Which School District provides services?  Any other service providers?
Are there any conditions that have not been addressed that your child has which could affect the child's every day activities?				

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rockin Round the Clock Staff Signature

\_\_\_\_\_  
Date

# Rockin Round the Clock Child Care Child History Form

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI MM DD YYYY

## Developmental History

### Age Child:

Rolled back to tummy \_\_\_\_\_ Rolled tummy to back \_\_\_\_\_ Sat up alone \_\_\_\_\_

Crawled \_\_\_\_\_ Got first tooth \_\_\_\_\_ Walked by self \_\_\_\_\_

Babbled \_\_\_\_\_ Spoke words \_\_\_\_\_ Spoke in full sentences \_\_\_\_\_

Speech difficulties \_\_\_\_\_

Does your child use special words to describe needs? \_\_\_\_\_

Does your child use a pacifier or suck his/her thumb or fingers? \_\_\_\_\_

Does your child have a fussy time? \_\_\_\_\_

How do you soothe your child? \_\_\_\_\_

## Family and Cultural History

With whom does your child reside? \_\_\_\_\_

Who else lives in the home? (siblings, extended family, pets) \_\_\_\_\_

What languages are spoken in your home? \_\_\_\_\_

Are books read to your child in languages other than English? \_\_\_\_\_

Are there words in your home language that we should know? \_\_\_\_\_

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: \_\_\_\_\_

## Social History

Has your child experienced play with other children? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Little \_\_\_\_ Some \_\_\_\_ Alot

Does your child usually play with: \_\_\_\_ alone \_\_\_\_ one child \_\_\_\_ a few children \_\_\_\_ many children

\_\_\_\_ younger children \_\_\_\_ children of his/her same age \_\_\_\_ older children

How does your child play with others? \_\_\_\_\_

Who usually initiates the play? \_\_\_\_\_

Is your child:  friendly  shy  withdrawn  aggressive  a leader  a follower  
 independent  dependent  attentive  distracted  confident  
 tends to follow directions  needs assistance with directions  has good self control  
 is working on mastering self control

Is your child currently enrolled in any other programming? \_\_\_\_\_

What are your child's favorite toys, activities, or interests? \_\_\_\_\_  
\_\_\_\_\_

How does your child respond to children he/she does not know? \_\_\_\_\_

How does your child respond to adults he/she does not know? \_\_\_\_\_

Is your child frightened by:  Animals  Strangers  Loud Noises  Storms  The Dark

Are there any fears not mentioned that we should be aware of? \_\_\_\_\_

Is your child confident or cautious when presented with new experiences or activities? \_\_\_\_\_

Does your child act differently (e.g. in terms of language, social skills, or physical skills) outdoors than while at play indoors? \_\_\_\_\_

## **Eating Habits**

Special characteristics or difficulties: \_\_\_\_\_

Any Food Allergies? \_\_\_\_\_  
\_\_\_\_\_

Favorite Foods \_\_\_\_\_ Foods refused \_\_\_\_\_

Child eats:  on lap  in a high chair  at the table  other (explain: \_\_\_\_\_)

Child eats with:  spoon  fork  hands  other (explain: \_\_\_\_\_)

## **Sleeping Habits**

Where does your child sleep?  crib  bed  other (explain: \_\_\_\_\_)

in own room  rooms with a sibling  rooms with parents

When does your child take naps? AM \_\_\_\_\_ PM \_\_\_\_\_ No Naps \_\_\_\_\_

What time does your child go to bed at night? \_\_\_\_\_ Awake in the morning? \_\_\_\_\_

What is your child like upon awakening? \_\_\_\_\_

Do you have any special sleep time rituals (special toy, favorite blanket, rocking, stories, routines) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Toilet/Diapering Habits**

Does your child have frequent diaper rash? \_\_\_\_\_

Do you use any special diapering products? \_\_\_\_\_

Brand of Diapers \_\_\_\_\_ Size of Diapers \_\_\_\_\_ Brand of Wipes \_\_\_\_\_

Are your child's bowel movements: \_\_\_\_ regular \_\_\_\_ irregular how often \_\_\_\_\_

Does your child have any problems with: \_\_\_\_ constipation \_\_\_\_ diarrhea

Is your child toilet trained: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ In training -----occasional accidents

Is there anything else you would like for us to know about your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Rockin Round the Clock Child Care Center**

951 NW 4<sup>th</sup> St  
Grand Rapids, Mn 55744  
218-326-9211

**Non-Prescription Medication – Authorization Only**

All over-the-counter (OTC) products need parental/guardian permission for administration. However, some of these external products do not need to be documented every time you use them. The following is a list requiring parental/guardian permission only.

**To be Completed by Parent/Guardian**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following external products may be applied to my child in accordance with the manufacturers instructions on the original container.

- \_\_\_\_\_ Diaper Wipes
- \_\_\_\_\_ Diaper Creams, Ointments
- \_\_\_\_\_ Skin lotions, creams, vasoline. Specify if special brand \_\_\_\_\_
- \_\_\_\_\_ Baby oil (Baby powder is not recommended due to inhalation hazards)
- \_\_\_\_\_ Soap. Specify if special brand \_\_\_\_\_
- \_\_\_\_\_ Sunscreen. Specify if special brand \_\_\_\_\_
- \_\_\_\_\_ Insect repellants. (cream or lotions only) Specify if special brand \_\_\_\_\_
- \_\_\_\_\_ Lip balm
- \_\_\_\_\_ Chemical hand sanitizers
- \_\_\_\_\_ Toothpaste
- \_\_\_\_\_ Other – please specify \_\_\_\_\_

Unused products: Shall be returned to parent/guardian? \_\_\_\_Yes \_\_\_\_No or will be discarded appropriately.

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

\_\_\_\_\_  
Date

All oral OTC medications need to be recorded on the Prescription Medication or the Non-Prescription Medication Forms, and kept in the child's file.

## **ALCOHOL DRUG/USE POLICY**

### **CHEMICAL USE POLICY**

The Rockin Round the Clock 24 hr Child Care Center will comply with MN Statute 245A.04, Subdivision 1© in making sure that prescription medications are taken as prescribed. We also assure that anyone responsible for the care and supervision of child care children in our center will not be under the influence of alcohol or drugs.

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

# CHILD CARE PROGRAM REPORTING NOTIFICATION

## Child Abuse

The reporting of suspected child abuse situations is a personal obligation as well as a professional and legal one. Minnesota State Statute, 245A.145, Subd. 1, requires that any of my employees/helpers or I report any form of physical, sexual or emotional abuse or neglect of any child in the center's care. When any of my employees/helpers or I, know, have reason to believe or suspect maltreatment has occurred, my employees/helpers or I will immediately, meaning as soon as possible but in no event longer than 24 hours, contact and make a report to the following:

1. Itasca County Health and Human Services Intake at (218) 327-2941; or
2. Local Law Enforcement (police) or Itasca County Sheriff at 9-1-1

Any person picking up a child in an impaired condition (under the influence of drugs or alcohol) will be encouraged to allow us to find alternate transportation. We cannot legally withhold a child from a parent or legal guardian; however, we will not hesitate to call the police if we feel the child is in jeopardy.

You may receive verbal reports or notes from us about your child having bruises or scrapes without needing to fear that we suspect you of abusing your child(ren). The verbal reports or notes that you may receive from us are just to alert you of any injuries noticed, and also to protect us from mistaken accusations of abuse.

## **Complaints About the Operation of a Child Care Center**

Communication between parents and the center is essential if your child is to receive consistent, nurturing care. When we accept a new family into our center, we like to be sure that we can share openly any concerns or questions that may arise. It is important that there is a similar childcare philosophy between us. We welcome questions, feedback, or discussions of any kind that affect positive outcomes for all children.

If concerns cannot be satisfactorily resolved between us, you may take your concerns to the following agencies:

1. Itasca County Health and Human Services Intake (for reporting suspected maltreatment) at (218) 327-2941
2. Minnesota Department of Human Services, Licensing Division, at (651) 296-3971

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Parent Signature

Date

Staff Signature

# Tennessen Warning

## Your Privacy Rights

This sheet tells you about your rights under the Minnesota Government Data Practices Act (the Act). This Act protects your privacy, but also lets us give information about you to others if a law requires it AND we tell you before we do it. The information Under the Act, information about individuals is divided into four categories.

### What kind of information do we collect?

- available to anyone. Public Information: Information about you that is
  - shared only if you give us your permission or if a law allows or requires us to share the information. Private Data: Information about you that can be
  - can't be shared about you. Confidential Information: Information about you that
  - does NOT identify you personally, which may be shared with others, generally for reporting purposes. Summary Information: Information about you that
- Generally, we only ask for two types of information from you – public and private information. We use summary information for reports but it does not identify you or anyone else by name or other identifying information.

### Why do we ask you for this information? - We ask this information so we can:

- Enroll your child in our child care center.
- Tell you apart from other persons with the same or similar name.
- Decide if you can receive services from us, and what or how much you can receive.
- Help you obtain financial or social services from other agencies or companies.
- Make reports, do research, audits, and evaluate our center programming.
- Collect money from the government for help we give

### Do you have to answer the questions we ask? What will happen if you do not answer the questions we ask?

Generally, you do not have to give us information. However, if you do not provide us the information, we may not be able to determine whether we can help you, or get help for you from other agencies.

### With whom may we share the information about you?

We may give information about you to the following agencies, if they need it to help you or help us help you. This does not mean we always share information about you with these people. It only says that there is a law that says we may share data with these people (sometimes the law says we MUST share certain information. If you have questions about when we give agencies information, please call Rockin Round the Clock Child Care Center office at 218-326-9211.

### These are the agencies we may share information with:

The MN Department of Education, and the school district where your child will be enrolled, other State or Federal agencies who provide program funding (State or local welfare agencies, community organizations, local, state, public and private human service agencies, the MN Department of Jobs and Training, the United States Department of Labor, the United States Department of Health and Human Services, and local educational programs, etc.

### You have the right to copies of information we have about

- You may ask if we have any information about you.
- If we have information about you, you may ask for copies.
- You may give other people permission to see and have copies of private data about you.
- If you do not understand the information, you may ask to have it explained to you.
- You may ask for and receive a copy of the agency's Data Practices

### How do you appeal if you think information is not accurate or complete?

Call Rockin Round the Clock Child Care Center office at 218-326-9211 and ask to speak to the Director. Your objections may also be in writing and sent to: 951 NW 4<sup>th</sup> St, Grand Rapids, MN 55744. You must tell us why the information is not accurate or complete. You may send your own

explanation of the facts you disagree with it. Your explanation will be attached any time that information is shared with another agency. For more information on how to do this please call Rockin Round the Clock Child Care Center office.

*If you have any questions about the information on this form, please call the Child Care Center office listed above.*

**Signature of Parent/Guardian**

**Date**

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# Rockin Round the Clock 24 Hr Child Care Center

## Parent/Child Permission Form

Participant's Name: \_\_\_\_\_

I give my permission for the Rockin Round the Clock 24 Hr Child Care Center to:

	Yes	No
Photograph my child for classroom display or center newsletter		

Photograph my child for newspaper articles or our website		
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Video tape my child for <u>center security purposes only</u>		
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Have my child participate in "walking explorations & experiences" within a four block radius of the center daily. Weather permitting they would walk on the sidewalk while either in the stroller or holding onto the walking rope, down two blocks, then go by the lake and back to the center. The staff to child ratio would be the same as inside the center.		
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Parent/Guardian Signature

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Date

**Rockin Round the Clock Parent Contract**  
**951 NW 4<sup>th</sup> Street**  
**Grand Rapids, MN 55744**  
**218-326-9211 or 218-259-1394**  
**Dan or Janet LeClair**

\_\_\_\_\_ Fees will be billed every two weeks. Payment must be received by the next billing cycle. Fees may be paid by cash or check.

\_\_\_\_\_ There is a four hour per day minimum fee for drop in children only (not attending regularly)

\_\_\_\_\_ A two week notice of termination of service is required, or the estimated time for two weeks will apply.

\_\_\_\_\_ Notify as soon as possible if child/children will be at the center longer than expected, or not attending for a scheduled day.

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Parent or Guardian

Date

Owner or Director

Date