PETITE ACADEMY

1810 N. 155th St. Shoreline, WA 98133

(206) 362- 8278

Child Care Agreement

Child/Children's name: First Middle Last							
Parent or guardian name: First] Middle] Last]							
Parent or guardian name: First Middle Last							
Days and times my child will receive care:							
Check days of care		☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	
Arrival time							
Departure time							

Fee: $ per: ☐ Hour ☐ Day ☐ Week ☐ Month	Date payment due: Source of payment: ☐ Parent ☐ Other (specify):
Overtime rate: $ per	Late fee: $ per
Other Fees: $ Description:	

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by

_____

Name of licensee

Parent or guardian signature Date	Parent or guardian signature Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street address City State Zip code

PETITE ACADEMY **Child Care Registration Form**				Date child entered care	Date child left care
Child's name	Last	First	Middle	Name used	Birthdate
Street address				City	Zip code
Child's parent/guardian name		10 digit home phone #		10 digit work phone#	10 digit cell #
Street address				City	Zip code
Address where you can be reached while child is in care				City	Zip code
Child's parent/guardian name		10 digit home phone #		10 digit work phone#	10 digit cell #
Street address				City	Zip code
Address where you can be reached while child is in care				City	Zip code

Other people to notify in case of emergency		
Name	Address	10 digit phone number
Relationship: Permission to pick up in emergency?		Work: Home: Cell:
Relationship: Permission to pick up in emergency?		Work: Home: Cell:
Relationship: Permission to pick up in emergency?		Work: Home: Cell:
Relationship: Permission to pick up in emergency?		Work: Home: Cell:

Other than you, who else has permission to pick up your child?		
Name	Address	10 digit telephone number
		Work: Home: Cell:
		Work: Home: Cell:
		Work: Home: Cell:

Who does not have permission to pick up your child?	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	10 digit telephone number
Street address	City	Zip code
Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.	
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.	
Child's dentist's name		10 digit telephone number
Street address	City	Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a qualified child care provider and/or staff at _____,

Name and address of provider

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

PETITE ACADEMY
1810 N. 155TH ST.
SHOELINE, WA 98133
TEL: (206) 362 8278

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I herebye give permission that my child, ---------- May be given emergency treatment by a qualified Daycare Staff member at Petite Daycare.

I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensend physiciant, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safegaurd my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Child's Name ---------- Birthdate----------

Allergies including Drug reactions

Chronic Illnesses

Regular Medications

Blood Type ----------

Date Of last Tetanus Immunization ----------

Other pertinent Data ----------

Child's Physician : Physicain's Phone Number :
Mother's work phone # : Father's Work phone # :
Cell # : Cell # :
Home # : Home # :

---------- ---------- ----------
Parent Name Parent Signature Date

PETITE ACADEMY
Permission Authorization

Child's name First Middle Last	Licensee's Name

The provider or assistant has permission to transport my child in a motor vehicle to go:

	Yes	No
1. On field trips	☐	☐
2. To and from school	☐	☐
3. To obtain medical care	☐	☐
4. On occasional errands	☐	☐
5. Other (specify below):	☐	☐

This permission is granted when the licensee follows all the requirements for transporting children. WAC 170-296-1250

The provider or assistant has my permission to:

	Yes	No
1. Take my child on walks	☐	☐
2. Take my child on public transportation	☐	☐
3. Take my child swimming	☐	☐
4. Take photographs of my child	☐	☐
5. Give my telephone number and address to other parents	☐	☐
6. Other (specify below):	☐	☐

Parent or guardian signature	Date	Parent or guardian signature	Date

PETITE ACADEMY

PARENT HAND BOOK , DISASTER PLAN,PESTICIDE VERIFICATION FORM

I/We have read the parent handbook, Disaster plan and pesticide policy and had the opportunity to review section with our child care provider. I/We understand the contents of the handbook and agree to follow the policies and procedures. I/We have been given a copy of the parent handbook for reference while our child is in care.

I/We understand that the provider may change policies and procedures at any time, will give us two weeks notice of changes, and changes will be presented to us in writing.

Parent/Guardian Signature **date**

Certificate of Immunization Status (CIS)

Washington State Department of Health

DOH 348-013 January 2010

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date Month	Day	Year
◆ **Hepatitis B (Hep B)**				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ **Diphtheria, Tetanus, Pertussis** (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ **Tetanus, Diphtheria, Pertussis** (Tdap, Td)				
	1			
	2			
● ***Haemophilus influenzae* type b (Hib)**				
	1			
	2			
	3			
	4			
● **Pneumococcal (PCV, PPSV)**				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date Month	Day	Year
◆ **Polio (IPV, OPV)**				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ **Measles, Mumps, Rubella (MMR)**				
	1			
	2			
◆ **Varicella (chickenpox)** or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name Date	Printed Staff Name Date
Printed Staff Name Date	Printed Staff Name Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, 3, OR 4 below – see, back #5.

1) ❑ Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP signed here and print name below:

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

3) ❑ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____(initial) _____(date)

4) ❑ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease: _____
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	
❑ Hib	❑ Tetanus	_____
❑ Measles	❑ Varicella	

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

Washington State Department of Health

DOH 348-106 June 2011

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements[1]

DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').[2] Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (mm/dd/yyyy):	**Sex:**	**Parent/Guardian Name** (please print):

Parent/Guardian, please choose the exemption(s) that apply to your child below.

☐ **Temporary Medical Exemption**
☐ **Permanent Medical Exemption**

_____ Until _____
Vaccine(s) Date (or Permanent)

Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X _____ X _____
Signature of Licensed Health Care Provider Date

☐ **Personal/Philosophical Exemption (see Box 1)**
☐ **Religious Exemption (see Box 1)**
☐ **Religious Membership Exemption (see Box 2)**

I do not want my child to get the following vaccine(s):

☐ Diphtheria ☐ Hepatitis B ☐ Hib
☐ Measles ☐ Mumps ☐ Pertussis (whooping cough)
☐ Pneumococcal ☐ Polio ☐ Rubella
☐ Tetanus ☐ Varicella (chickenpox)

☐ Other (indicate):

Box 1

Provider Statement[2]: "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons."

X _____
Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X _____
Date

Box 2

Parent/Guardian Demonstration of Religious Membership: "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption."

X _____
Name of Church or Religious Body

X _____ X _____
Signature of Parent or Guardian Date

Box 3

Parent/Guardian Statement: "I certify that all the information provided on this certificate is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care, or preschool until the outbreak is over."

X _____ X _____
Signature of Parent or Guardian Date

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

[1] RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

[2] A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month – Tell us how much and how often (or net income if self-employed) (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	*$200 / weekly*	*$150 / 2x/month*	*$100 / monthly*	
1.	$ /	$ /	$ /	
2.	$ /	$ /	$ /	
3.	$ /	$ /	$ /	
4.	$ /	$ /	$ /	
5.	$ /	$ /	$ /	
6.	$ /	$ /	$ /	

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing / Social Security Number (last four digits) XXX-XX-	☐ I do not have a Social Security Number
Address	City/State/Zip Code	Daytime Phone	

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

CENTER USE ONLY

☐ Child(ren) are categorically ☐ free based on ☐ Basic Food ☐ TANF ☐ FDPIR

☐ Foster child(ren) have been identified on this form and qualify for the ☐ free category.

Annual Income Comparison: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:

Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

_____ _____
Signature of Institution's Representative Date

Valid for one year from the date of the institution representative's signature. **Invalid without signature and date.**