SHERMAN COUNTY Sprouts

THE FUTURE GROWS HERE.

Office Use Only
Enrollment Date:
Immunization Rec.

Sherman County Sprouts will be open Monday-Friday.
The hours for childcare will be 7:00AM – 6:00PM.

Child's Information

Child First Name: _____ Last Name: _____

DOB or Due Date: _____ Sex: _____

1st Parent/Guardian

First Name: _____ Last Name: _____

Home Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Personal Email Address: _____

Employment: _____

Work Address: _____ City, State: _____ Zip: _____

Work Phone: _____ Work Email: _____

2nd Parent/Guardian

First Name: _____ Last Name: _____

Home Address: _____ City, State: _____ Zip: _____

(If different than above)

Home Phone: _____ Cell Phone: _____

Personal Email Address: _____

Employment: _____

Work Address: _____ City, State: _____ Zip: _____

Work Phone: _____ Work Email: _____

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Emergency Contacts and Release

People to contact in case of an emergency if parents cannot be reached.

1. Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____

Home Address: _____

2. Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____

Home Address: _____

Authorized Pick Ups

We request that all authorized pick-up persons with whom staff is not familiar with provide a **photo ID at the time of pick up**

Name: _____ Relationship to Child: _____

Phone: _____

Name: _____ Relationship to Child: _____

Phone: _____

Name: _____ Relationship to Child: _____

Phone: _____

Parents Signature: _____ **Date:** _____

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Consent to Contact Physician in Emergency

In the event I cannot be reached to make arrangements, nor those listed in the Child Emergency Contact and Release, I hereby give my consent to Sherman County Sprouts to contact,

(Doctor) _____

(Phone Number) _____ (Address) _____

And if necessary, take my child to the following Doctor(s), clinic, or hospital

_____

Parents Signature: _____ **Date:** _____

Medical Information

Any health conditions which caregiver should know:

_____

_____

Medication, if any: _____

Allergies, if any: _____

Special Concerns: (Glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Any additional information that we need to know about your child:

_____

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Diaper Cream/Sunscreen/Insect Repellent

I gave my permission for the center to apply the following to my child. I understand that I must supply my own with valid expiration date, and it will be labeled with my child's name.

☐ Sunscreen ☐ Insect Repellent ☐ Diaper Cream Brand: _____

☐ I do not give the center permission to apply sunscreen, insect repellant, and diaper cream to my child.

Parent Signature: _____ **Date:** _____

Photo Release

I understand that my child, listed above, may be photographed at Sherman County Sprouts during normal hours, field trips, or family activities. I understand that these photographs may be used in promoting childcare services, either in print, on our website, social media, and/or newsletters.

With my signature I grant permission for my child to be photographed, or their image recorded for print or electronic use in promoting Sherman County Sprouts services. I understand that it is my responsibility to update this form if I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Name: _____ Date: _____

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Permission for Off-Site Outings

☐ As a parent, I give my permission for my child to leave the center with a qualified staff member for off-site "walking/education purpose" outings which may include, but not limited to the following:

Group outings, nature walks, scavenger hunts, plant/animal observations, picnics.

☐ As a parent, I DO NOT give my permission for my child to leave the center.

*Staff to child ratio will **always** be maintained when leaving Sherman County Sprouts.*

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Name: _____ Date: _____

SHERMAN COUNTY Sprouts

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Parent Enrollment Agreement

Please initial each section and sign below.

Starting on _____ a weekly rate of $175 will be charged.

Creating a total tuition bill of $350 due bi-weekly.

*Automatic withdrawal payments will be taken every other Friday prior to the 2 weeks of service

	Tuition is not subject to discounts for holidays, emergency closures (i.e. weather) or absence other than hospitalization at the request of a doctor (a written doctor's note is required to receive credit)
	I agree to pay the full tuition in advance of services rendered.
	I agree to pay the full tuition fee even if my child is absent for one or more days.
	We have the right to charge a late fee of $25.00 if tuition is not received on time.
	A late pick-up fee of $1 per minute per child is due if my child is not picked up by 6:00PM.
	Accounts two weeks in arrears may result in immediate termination of service.
	A two-week written notice is requested for any child being withdrawn from the program.
	Prior to enrollment, I must provide the center with updated medical and immunization information for my child, this information is to be kept current and update in accordance with the state childcare regulations.
	I agree to provide information to the childcare center about my child's conditions, illnesses, allergies, or other needs.

Parents Signature: _____ **Date:** _____

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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

Parent Information Brochure For Licensed Child Care

Nebraska Child Care Licensing Website:
http://dhhs.ne.gov/licensure/pages/Child-Care-Licensing.aspx

Expectations of Child Care Consumers

Read thoroughly all the information your provider gives you.

Complete your Child's Record Forms and return to your provider before your child begins care. Review and update these records as needed.

Supply your provider with your child's immunization records and keep them updated as needed.

Sign and date the receipt of this Parent Information Brochure for Licensed Child Care and return it to your provider before your child begins care.

Talk to your Child Care provider regularly to address needs and concerns for your children in care and as a parent.

Contact Child Care Licensing with any questions or concerns you may have.
Email: DHHS.ChildCareLicensing@nebraska.gov
Phone: 800-600-1289 OR 402-471-6564
Mail: Nebraska Child Care Licensing
Department of Health and Human Services
PO Box 94986
Lincoln, NE 68509-4986

Sign, date and return to your Child Care provider before your child(ren) begin care.
Your Child Care Provider must retain this receipt for onsite review.

Child Care Program Name: _____

Enrolled Child(ren)' Names: _____

Parent/Guardian Names: _____

Parent/Guardian Signature: _____

Licensed Child Care

You have chosen to use a licensed Child Care provider for the care of your child or children. Nebraska Law requires anyone providing care to four or more children from different families, for compensation, to be licensed. The Types of Licensed Child Care in Nebraska are:

Family Child Care Home I
Family Child Care Home II
Preschool
Child Care Center
School–Age Only Center

Responsibilities of Child Care Licensing

The roles and responsibilities of DHHS Child Care Licensing staff are to ensure that programs are providing proper care for and treatment of the children they serve, and that the care and treatment are consistent with the child's physical well-being, safety, and protection.

Licensed Child Care programs are encouraged to involve you. We urge you to let your Child Care providers and/or staff know of any concerns. There may be situations where you believe that the program is not responding to your concerns or may not be meeting state licensing standards. This brochure, which Child Care providers are required to share with you, provides information that might be helpful in those situations.

Please complete the receipt section and return it to your Child Care provider. This will be kept with your child's records.

Responsibilities of Licensed Child Care Provider

Comply with child care regulations for their license type at all times.

Obtain and maintain accurate records for children they have in care, such as Enrollment Forms, Parent Information Brochure Receipts, Immunization Records and Medication Administration records.

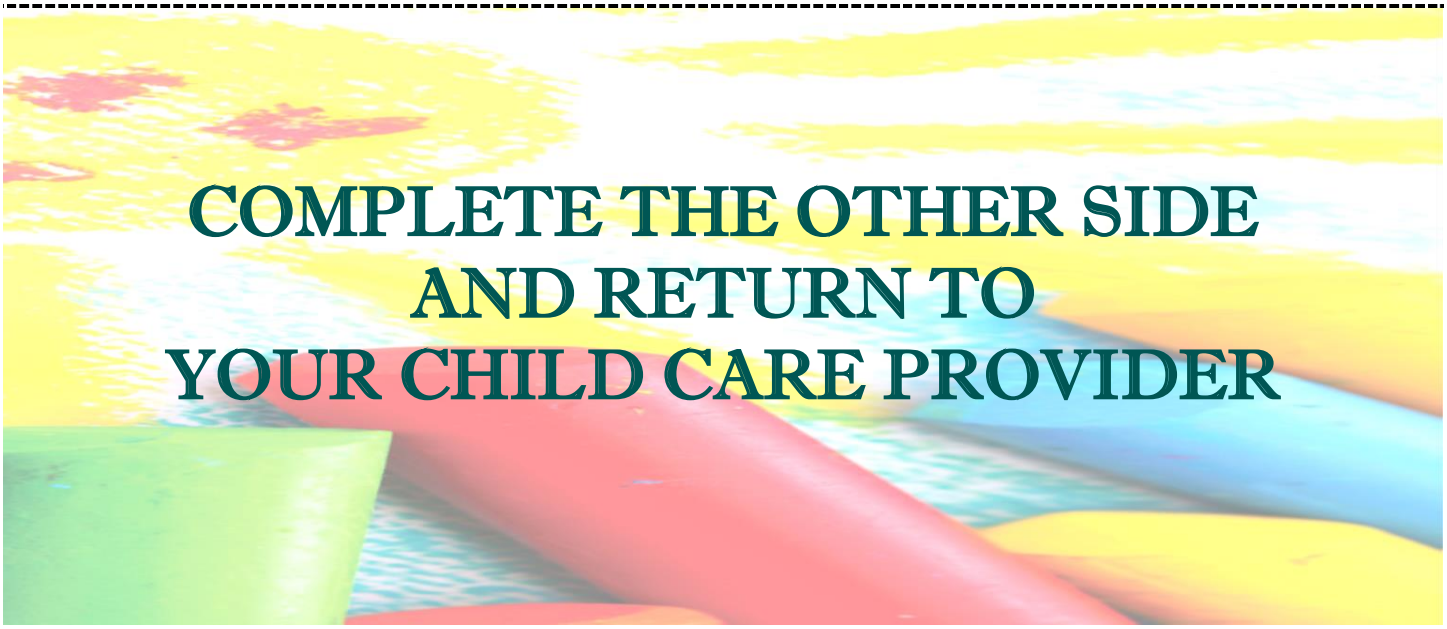
Keep accurate and up-to-date records for their license on themselves and staff members. Report changes to Child Care Licensing and complete required paperwork to reflect changes.

Allow access to their licensed facility when children are in care at all times to parents, Child Care Licensing representatives and the Fire Marshal.

Develop policies and procedures for their programs.

Communicate with families their needs and concerns for the children in care.

Contact Child Care Licensing with any questions or concerns they may have.



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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

IMMUNIZATION RECORD

Child(s) Name:

Birthdate(s): | Enrollment Date:

REQUIRED IMMUNIZATIONS

Vaccine	Type of Vaccine	Dose	Normal Schedule	Date Given Mo	Day	Yr	Doctor or Clinic Administering
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6 - 18 mo.				
		4	4 - 6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15 - 18 mo.				
		5	4 - 6 yrs.				
Tdap		1	11 - 18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12 - 15 mo.				
M-M-R		1	12 - 15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox date of disease		1	12 - 18 mo.				
		2					
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12 - 15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian:_____ Date:_____

I do not wish to have (child's name)_____immunized. The reason for the decision is:

_____

Signature of Parent/Guardian:_____ Date:_____

Child Care Medication Authorization Form

Name of Child:_____ D.O.B.:_____ Today's Date:_____

Name of Medication:_____

Reason for Medication:_____

Dose:_____ Time/Frequency: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other

Date to Start:_____ Date to stop:_____ Expiration:_____

Additional Instructions/Comments: _____

_____

Known side effects:_____

_____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider:_____

Phone Number: _____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received:_____

Staff Member Signature:_____

Staff Member Signature:_____

I authorize (*child care center*) _____ personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____ **Date Signed:** _____

Parent/guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date:_____ Parent Signature:_____

Disposal Date:_____ Staff Signature:_____

Witness to Disposal: _____