

Fall 2019-2020

Guardian Information

Registration Date: _____

Guardian First Name: _____ M.I. _____ Last Name: _____

Address: _____

Relationship to child: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Cell Phone: () _____

Custodial Guardian (If married, mark both parents) Guardian SS#: _____

Email: _____ Occupation: _____

Preferred PIN number for door code (4 digits, numbers only) 1st choice _____ 2nd Choice _____

Guardian First Name: _____ M.I. _____ Last Name: _____

Address: _____

Relationship to child: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Cell Phone: () _____

Custodial Guardian (If married, mark both parents) Guardian SS# _____

Email: _____ Occupation _____

Preferred PIN number for door code (4 digits, numbers only) 1st choice _____ 2nd Choice _____

Trinity Educare Program requires a \$75 non-refundable registration fee each year.

- I have read, understand and will comply with all the policies and procedures outlined in the Family Handbook, and that the Health Policy and Disaster Plan are available for review.
- I am responsible for payments of fees based on the enrollment schedule, including holidays and days children are ill.
- I agree that if payment is not made per the agreement, we may be asked to leave the program.
- I will give the center 2 weeks notification if a schedule change or withdrawal from the program is needed.

Guardian Signature _____

Date _____

1st day at Trinity Educare: _____

Child Information

1st Child First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: _____

Gender: Male Female Date of Birth: _____ Date of last physical exam: _____

List any existing medical conditions, medication and/or special attention your child may require?

Allergies: _____

Food allergies and/or intolerance: _____

Pediatrician's Name: _____ Phone: () _____

Address: _____

Dentist Name: _____ Phone () _____

Address: _____

_____ **Full Days**

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

_____ **Half Days** (up to 5 hours per day) Choice either (AM 6:30-12:00) or (PM 12:00-6:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

_____ **Kindergarten After School Care** (at 11:45am-3:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

_____ **Before and After School Care** (School-age children) (AM from 6:30-8:30) (PM from 3:00pm-6:00pm)

Days of the week to be enrolled M(AM)___ M(PM)___ Tu(AM)___ Tu(PM)___ W(AM)___

W(PM)___ Th(AM)___ Th(PM)___ F(AM)___ F(PM)___

2nd Child First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: _____

Gender: Male Female Date of Birth: _____ Date of last physical exam: _____

List any existing medical conditions, medication and/or special attention your child may require?

Allergies: _____

Food allergies and/or intolerance: _____

Pediatrician's Name: _____ Phone: () _____

Address: _____

Dentist Name: _____ Phone () _____

Address: _____

Child Information - Continued

Full Days

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Half Days (up to 5 hours per day) Choice either (AM 6:30-12:00) or (PM 12:00-6:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Kindergarten After School Care (at 11:45am-3:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Before and After School Care (School-age children) (AM from 6:30-8:30) (PM from 3:00pm-6:00pm)

Days of the week to be enrolled M(AM)___ M(PM)___ Tu(AM)___ Tu(PM)___ W(AM)___

W(PM)___ Th(AM)___ Th(PM)___ F(AM)___ F(PM)___

3rd Child First Name: _____ M.I. ___ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: _____

Gender: [] Male [] Female Date of Birth: _____ Date of last physical exam: _____

List any existing medical conditions, medication and/or special attention your child may require?

Allergies: _____

Food allergies and/or intolerance: _____

Pediatrician's Name: _____ Phone: () _____

Address: _____

Dentist Name: _____ Phone () _____

Address: _____

Full Days

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Half Days (up to 5 hours per day) Choice either (AM 6:30-12:00) or (PM 12:00-6:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Kindergarten After School Care (at 11:45am-3:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Before and After School Care (School-age children) (AM from 6:30-8:30) (PM from 3:00pm-6:00pm)

Days of the week to be enrolled M(AM)___ M(PM)___ Tu(AM)___ Tu(PM)___ W(AM)___

W(PM)___ Th(AM)___ Th(PM)___ F(AM)___ F(PM)___

4th Child

First Name: _____ M.I. _____ Last Name: _____

Name child prefers to be called: _____ Grade/Class: _____

Child's Address: _____

Gender: [] Male [] Female Date of Birth: _____ Date of last physical exam: _____

List any existing medical conditions, medication and/or special attention your child may require?

Allergies: _____

Food allergies and/or intolerance: _____

Pediatrician's Name: _____ Phone: () _____

Address: _____

Dentist Name: _____ Phone () _____

Address: _____

Full Days

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Half Days (up to 5 hours per day) Choice either (AM 6:30-12:00) or (PM 12:00-6:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Hours: From: _____ to _____

Kindergarten After School Care (at 11:45am-3:00pm)

Days of week to be enrolled: M ___ Tu ___ W ___ Th ___ F ___

Before and After School Care (School-age children) (AM from 6:30-8:30) (PM from 3:00pm-6:00pm)

Days of the week to be enrolled M(AM) ___ M(PM) ___ Tu(AM) ___ Tu(PM) ___ W(AM) ___

W(PM) ___ Th(AM) ___ Th(PM) ___ F(AM) ___ F(PM) ___

Trinity Catholic School
Educare Program

I hereby grant permission for my child to use all of the play equipment and participate in all of the activities at Trinity Educare.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical, hospital or dental care if warranted. These steps may include, but are not limited to the following:

- Attempt to contact a guardian.
Attempt to contact you though any of the persons listed on the emergency information form completed by you.
Attempt to contact the child's physician.
While attempting to contact the physician, we will do any or all of the following:
Give emergency treatment to include first aid and/or CPR by a qualified staff member.
Call another physician (if yours cannot be reached) or paramedics.
Call an ambulance
Have a child taken to an emergency hospital in the company of a staff member.
Grant permission to the hospital and physicians to proceed with medical care and/or emergency surgery.
Any expenses incurred under bullet 4, above, will be borne by the child's family.
Trinity Catholic School and Educare will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
Trinity Catholic School and Educare will not assume responsibility for a child who has not been signed in when he/she arrives for the day.

Guardian Signature

Date

Emergency Contacts & Authorized Pickup Persons:

Revised: Fall 2019-2020

Child's name: _____

1st Guardian Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

2nd Guardian Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

3rd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

4th Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

5th contact/Pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

6th contact/Pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

7th contact/pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

8th contact/pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

9th Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

10th Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

11th contact/Pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

12th contact/Pick-up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for door code (4 digits, numbers only) _____

Able to pick up all children in the family

Emergency contact

Not able to pick up the following children: _____

Getting to know me!

We would like to learn more about your child. The more we know about your child the better we can meet their needs. Please answer questions below.

Childs Name: _____

Name you child like to be called? _____

My child lives with these adults? _____

My child lives with _____ other children. Their names and ages are? _____

Do you have any family pets? _____

We speak the following languages in our family? _____

What activities does your child really enjoy? _____

Who are the family members or friends your child most enjoys spending time with? _____

What are some things family members or friends do with your child? _____

What helps your child feel more comfortable in social situations? _____

How does your child respond to new situations or challenges? _____

Here are some ideas to help support my child when they are frustrated, angry, or sad? _____

What motivates your child? _____

What is your child's strength? _____

What is your family's culture and beliefs (if applicable)? _____

What is your family's child rearing practices (the way you raise your children)? _____

Is there anything else you would like us to know about your child? _____



Termination of Services Policy

Unfortunately, there are sometimes reasons that Trinity Educare Center will have to ask families to be removed from our program. We want you to know we will do everything possible to work with your family to prevent this policy from being enforced.

Examples for termination are (but not limited to):

- Failure to pay/habitual lateness in payment
- Failure to complete required forms for child's file
- Verbal abuse to staff/children
- Guardian threatens physical or intimidating actions toward staff members
- Failure to comply with the family handbook

Guardian Signature:

Date: _____

Name of child registered in program (1) _____

Name of child registered in program (2) _____

Name of child registered in program (3) _____

Name of child registered in program (4) _____



Expulsion Policy

It is our goal to work closely with guardians in all situations to make sure that an expulsion does not occur. Unfortunately, there are situations that we have to ask that a child be removed from our program either on short term or permanent basis. We want you to know that we will do everything possible to work with the family of the child(ren) in order to prevent this policy from being enforced.

When a child is having challenges in the classroom:

- Staff will try to redirect the child from negative behavior.
- Staff will reassess classroom environment, activities and supervision.
- Staff will always use positive methods and language.
- Staff will praise appropriate behaviors.
- Children will be given verbal warnings.
- Children will be given time to regain control.
- Children with challenging behavior will be documented and kept confidential.
- Guardian will be notified verbally.
- Guardian will be given written copies of challenging behavior that may lead to expulsion.
- The director, lead teacher and guardian will have a conference(s) to discuss behavior.
- Recommendation for evaluation by professional

If after the actions above have not helped the child. Guardians will be told in person and in writing about the child's behavior warranting expulsion.

If we are calling to have your child pick-up for the day or longer, we are requiring your child to be pick-up within the hour that we make the first call.

Examples of child behaviors that could lead to expulsion (but not limited to):

- Uncontrollable tantrums/angry outburst
- Ongoing physical or verbal abuse to self, staff or children
- Excessive biting

Guardian Signature: _____

Date: _____

Name of child registered in program (1) _____

Name of child registered in program (2) _____

Name of child registered in program (3) _____

Name of child registered in program (4) _____



Family Handbook Acknowledgement

I, the undersigned, acknowledged that I have received a copy of the Family Handbook for Trinity Educare Center. While I understand that the Family Handbook is neither a contract nor a legal document, I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Family Handbook.

I recognize that it is my responsibility to contact the Trinity Educare director for any questions I might have about the contents of the Family Handbook.

Guardian Signature _____

Date _____

Child Registered in Program (1) _____

Child Registered in Program (2) _____

Child Registered in Program (3) _____

Child Registered in Program (4) _____



Early Achievers: Parent/Guardian Consent for On-Site Evaluation

Dear Families,

As you know, _____ is participating in Early Achievers and we are preparing to demonstrate our commitment to providing quality care and education through an on-site evaluation. **We need your help to make this effort a success!** Please read below for more information on how you can help us continue to provide high-quality care that helps children learn and grow.

On-Site Evaluation:

Child care and early learning programs that participate in Early Achievers receive on-site evaluation visits from the University of Washington (UW). The purpose of the evaluation visit is to gather information about our program to inform our Early Achievers quality rating. An on-site observation of our learning environment during operating hours is part of our evaluation.

The evaluation includes collecting information that will be used to validate our quality and help us, _____, develop goals to continue improving the quality of care we provide for your child, such as:

- Observing interactions between providers and children.
- Observing the materials, activities and experiences available to support children in the learning environment.
- Observing children engaging with the learning environment to understand how it stimulates their learning.
- Interviewing providers about how they support young children's growth and development.
- Interviewing interested families to learn about how we partner with families to support their child's learning and development.
- Reviewing program files and documentation to learn how program policies and procedures support quality child care practice.
- Reviewing child files to see how our program supports each child's learning and development.

Please note:

- Your child's care and education will not be interrupted during this process.
- No information about your child will ever be released to the public.
- No identifiable information about individual children will be collected.
- Information about our participation will be posted on the Department of Early Learning and Child Care Aware of Washington websites. (del.wa.gov and wa.childcareaware.org)



Early Achievers: Parent/Guardian Consent for On-Site Evaluation

Please let us know if your child's files can be included during the evaluation visit.

- I allow my child's files to be reviewed as part of the Early Achievers evaluation as outlined above.
- I would like my child's files to be excluded during this process.

Child care facility name: _____

Child name: _____

Parent/Guardian name (printed): _____

Signature: _____ Date: _____

Optional: The UW data collection team would like to hear what you think about how we work with children and families. If you are interested in participating in an interview with the UW team, please indicate below:

Yes, I am interested and willing to be contacted by UW for an interview (Note: *not all families who check yes will be contacted*)

Please contact me by phone

Phone number _____

Best time to reach me _____

Please contact me by email so I can access a link to an online parent survey

Email address _____



Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

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 Washington Immunization Information System.

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (MM/DD/YY): _____	Sex: _____
I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.		I certify that the information provided on this form is correct and verifiable.		
Parent/Guardian Signature Required _____		Parent/Guardian Signature Required _____		
Date _____		Date _____		

	Date	Date	Date	Date	Date	Date
♦ Required for School and Child Care/Preschool ● Required Only for Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ DTaP / DT (Diphtheria, Tetanus, Pertussis)						
♦ Tdap (Tetanus, Diphtheria, Pertussis)						
♦ Td (Tetanus, Diphtheria)						
♦ Hepatitis B <input type="checkbox"/> 2-dose schedule used between ages 11-15						
● Hib (<i>Haemophilus influenzae</i> type b)						
♦ IPV / OPV (Polio)						
♦ MMR (Measles, Mumps, Rubella)						
● PCV / PPSV (Pneumococcal)						
♦ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity
Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it **MUST** be verified by a healthcare provider

I certify that the child named on this CIS has:

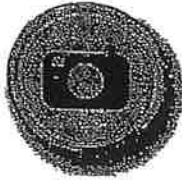
a verified history of Varicella (Chickenpox).

laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other:
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

Licensed healthcare provider signature _____ Date _____

Printed Name _____



Permission to Photograph

I, _____, give permission for _____ to
(Parent or Guardian name) (Child Care Provider)
 photograph my child, _____, for the following purposes:
(Child's name)

Type of Use:	(Please check one)	
	Grant Permission	Decline Permission
Still Photographs:		
Display in classrooms	<input type="checkbox"/>	<input type="checkbox"/>
Give group photographs possibly containing your child to current clients	<input type="checkbox"/>	<input type="checkbox"/>
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients	<input type="checkbox"/>	<input type="checkbox"/>
Display still photos on child care website*	<input type="checkbox"/>	<input type="checkbox"/>
Post photos on Trinity's Facebook page*	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Videos:		
Email or send group videos to current parents	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):		
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

*Names will not be displayed on the facility's website or Facebook page.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment

Signed:

(Parent or Guardian signature)

(Date)