2-3-4
ENROLLMENT
PAPERWORK

L&H
LUTHERAN HOME
Children's Center
7500 West North Avenue, Wauwatosa, Wisconsin 53213 | thelutheranhome.org | 414.258.6171

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4. and DCF 251.04(6)(a)8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other HealthCheck provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other HealthCheck Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian | Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

First Aid Permission and Emergency Information

First Aid Permission

Child's Name_____ Age _____

I give The Lutheran Home Children's Center permission to administer first aid to my child. In case of emergency, the school staff promptly contacts the parents. If neither parent nor the emergency phone number can be reached, and in case of surgical emergency, I hereby give permission to the physician selected by the Lutheran Home Children's Center Administrator to hospitalize and secure proper treatment for my child as named above.

Signature_____ (Parent of Guardian) Date_____

Emergency Information

Please check one:

☐ Our family has health insurance

☐ I refuse to provide Health information

Health insurance information to be used only in emergencies:

Policy Holder Name: _____

Company: _____

Policy/subscriber number: _____

I authorize the following individuals to have access to my child's health information: (check all that apply)

☐ Emergency medical personnel

☐ Emergency contact who is authorized to pick up my child (Child Enrollment Form)

☐ Child Care Staff

☐ Other: _____

LUTHERAN HOME

Child Classroom Information

Child Contact Information for Emergency

Child:_____ Birth Date:_____

Parent: _____ Parent: _____

Address:_____

Parent Phone:_____ Parent Phone:_____

Email Address: _____

Emergency Contact Name and Number: _____

Physician's Name: _____ Number:_____

I give The Lutheran Home Children's Center Permission to arrange for emergency medical care if needed.

_____ _____

Parent signature Date signed

Child Permission Information

Sunscreen Application Permission

- ☐ I give permission for LHCC staff to apply Rocky Mountain Sunscreen (SPF 30) to my child as needed
- ☐ I will provide sunscreen and give permission for LHCC teachers to apply to my child as needed
  Sunscreen Brand:_____ SPF:_____
- ☐ Do not apply sunscreen to my child at any time
- ☐ I give permission for LHCC Staff to apply insect repellant to my child as needed
  Insect Repellant Brand: _____

_____ _____
Parent signature Date signed

Neighborhood Walks Permission

The Lutheran Home Children's Center Staff has my permission to take my child on neighborhood walks. Besides the surrounding neighborhood, these may include the Wauwatosa Library and Roosevelt Elementary School Playground.

_____ _____
Parent signature Date signed

Animal Interactions Permission

- ☐ I give permission for my child to interact with pet therapy animals during Intergenerational Programming
- ☐ I give permission for my child to participate in animal interaction events-such as Urban Ecology events

_____ _____
Parent signature Date signed

Special Treat Permission

- ☐ I give permission for my child to eat special event treats and snacks
- ☐ I will provide my child's own snacks for special event treats and snacks

_____ _____
Parent signature Date signed

Family Questionnaire

To help us understand you and your family better, please fill out this questionnaire. This will be used by your child's teachers and will be kept in your child's confidential file.

Parent Information:

Child's Name:_____

Mother's Name: _____

Mother's Profession: _____ Mother's Workplace: _____

Father's Name: _____

Father's Profession: _____ Father's Workplace: _____

Please list any skills or hobbies you would like to share with us.

_____

Are there any ways you would like to volunteer in your child's classroom?

Some examples might be:

- ☐ Read stories to the class
- ☐ Share a profession
- ☐ Share a talent
- ☐ Prepare projects
- ☐ Volunteer for Family Night events
- ☐ Volunteer a morning, afternoon, or full day
- ☐ Anything I can do at home
- ☐ Other _____

Family Information

What language is spoken in your home? _____

Do you have a religious preference? _____

Do you have any cultural traditions that you follow _____

_____

If so, would you like to share them?

_____

How would like to help the teacher's incorporate this information into your child's care?

_____

Please feel free to stop by or visit our Center at any time throughout the day. You are always welcome!

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Photo/Media Permission

I, _____ authorize the Lutheran Home Children's Center to use the likeness of my child, _____ in photography and video clips taken by the Lutheran Home Children's Center Staff for appropriate classroom and center use. I understand that these may be used in NAEYC classroom and program portfolios, newsletters, art projects, bulletin board displays, and teacher's school related assignments. They may also be posted in common areas where residents, families, and employees can view them. On occasion you may be asked further permission for your child's likeness to be used in Lutheran Home marketing, for example, a photo of your child and a resident may be used to highlight our intergenerational program.

Parent signature:_____ Date: _____

I also give permission for my child's likeness in photos or video clips to be posted on The Lutheran Home Children's Center Facebook Page. For example, during the Week of the Young Child, pictures of special activities are posted from each day. No child names are listed when these are posted. (However if you like and you are on Facebook, you can tag and share with your friends.

Parent signature:_____ Date: _____

Ointment Permission Form

Please indicate below the item(s) that you would like us to use with your child. You will need to supply this item and inform us of any changes from the information below. Please check all that apply.

Desitin Ointment

- ☐ Apply **Desitin Ointment** according to directions at every diaper change in which the affected area is red or has a rash.
- ☐ Apply **Desitin Ointment** according to directions at every diaper change even if the affected area is not red or does not have a rash.

A & D Ointment/Cream

- ☐ Apply **A & D Ointment/Cream** according to directions on label at every diaper change in which the affected area is red or has a rash.
- ☐ Apply **A & D Ointment/Cream** according to directions on label at every diaper change even if the affected area is not red or does not have a rash.

Triple/Butt Paste

- ☐ Apply **Triple/Butt Paste** according to directions on label at every diaper change in which the affected area is red or has a rash.
- ☐ Apply **Triple/Butt Paste** according to directions on label at every diaper change even if the affected area is not red or does not have a rash.

Aquaphor

- ☐ Apply **Aquaphor** according to directions on label at every diaper change in which the affected area is red or has a rash.
- ☐ Apply **Aquaphor** according to directions on label at every diaper change even if the affected area is not red or does not have a rash.
- ☐ Apply **Aquaphor** according to directions on label to areas on the body which have a rash.

Eucerin

- ☐ Apply **Eucerin** according to directions on label to areas on the body which have a rash at every diaper change.
- ☐ Apply **Eucerin** according to directions on label to areas on the body which have a rash during diaper changes _____ (indicate number of times to apply) times a day.

Cetaphil

- ☐ Apply **Cetaphil** according to directions on label to areas on the body which have a rash at every diaper change.
- ☐ Apply **Cetaphil** according to directions on label to areas on the body which have a rash during diaper changes _____(indicate number of times to apply) times a day.

_____(Other Cream)

- ☐ Apply _____ according to directions on label at every diaper change in which the affected area is red or has a rash.
- ☐ Apply _____ according to directions on label at every diaper change even if the affected area is not red or does not have a rash

Child's Name: _____ Parent Signature: _____ Date: _____

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Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) hereby authorize _____ , (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

_____ _____
Your Name Phone #

_____
Address

_____
City State Zip

_____
DEPOSITORY - Bank or Credit Union Name

_____
Bank or Credit Union Address

_____
City State Zip

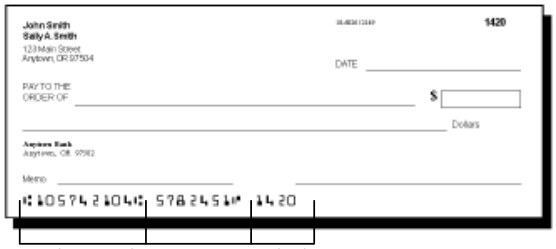
Type: ☐ Checking ☐ Savings

_____ _____
Routing Transit Number (see sample below) **Account Number** (see sample below)

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

_____ _____
Signature Date

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.



Please attach a copy of a voided check here.
Deposit slips not accepted.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.

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For Credit Card Authorization, complete and return to center management.

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize _____ (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "CENTER". I (we) authorize CENTER to utilize Tuition Express* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

_____ _____
Cardholder Name Phone #

_____ _____
Cardholder Billing Address Account Number

_____ _____
City State Zip Expiration Date

_____ _____
Cardholder Signature Date

*Tuition Express is an assumed business name of Blum Investment Group, Inc.

For Official Use Only:

Date Received: _____

Employee Signature: _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

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