Registration Packet

1. Day Care Enrollment Form
2. Medical Form (To Be Completed By Physician)
3. Cumulative Health Record
4. Pick Up Authorization
5. Transportation Agreement
6. Feeding Schedule
7. Sleeping & Napping Agreement
8. Outdoor Activity Permission Form
9. Weekly Schedule
10. Emergency Contacts
11. Allergy Forms
12. Enrollment Checklist

- BE SURE TO COMPLETE AND RETURN EVERY FORM
  (IF FORM DOESN'T APPLY TO YOU, RETURN ANYWAY)
- YOU MAY SCAN BACK BY EMAIL TO:
  CONTACTUS@PEARTREEEXPLORERS.COM
- ANY QUESTIONS CALL 718-219-0402
- REGISTRATION FEE: $50 (SEND VIA ZELLE TO 718-219-0402)

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -

CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:
CHILD'S HOME ADDRESS:		

NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) ____________________

☐ Other ____________________

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child.......... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.......... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.......... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child.......... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.......... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year.......... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District Number** __ __ __ __ __ | **Phone Numbers** Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** | **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height ______ **cm** (___ ___ %ile)

Weight ______ **kg** (___ ___ %ile)

BMI ______ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* ______ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl *Abnl*	*Nl* *Abnl*	*Nl* *Abnl*	*Nl* *Abnl*	*Nl* *Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	***Date Done***	***Results***
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____ /____ /____	______ μg/dL
	____ /____ /____	______ μg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____ /____ /____	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	____ /____ /____	______ g/dL ______ %

Hearing	***Date Done***	***Results***
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	***Date Done***	***Results***
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____ /____ Left ____ /____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

												IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap		___/___/___	___/___/___		Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___		Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___		Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___		Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___		Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___		Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___		Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other ______	___/___/___	______	___/___/___		Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______ ______

______ ______

______ ______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature | Date Form Completed _____ /_____ /_____ | **DOHMH ONLY** **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip | Date Reviewed: _____ / _____ / _____ **I.D. NUMBER**

REVIEWER:

Telephone | Fax | Email | **FORM ID#**

CENTER
NAME:
ADDRESS:
BORO:

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ___/___/___

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)	SEX F ❑ M ❑	DATE OF BIRTH / / Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)		
MOTHER'S NAME: (First) (Last) FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT		
FOSTER AGENCY ADDRESS		TELEPHONE #
LANGUAGE SPOKEN IN HOME		

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*

NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(_____) Sickle Cell	(_____) Heart Disease	(_____) Medications *(Specify)*
(_____) Diabetes	(_____) Hypertension	(_____) None
(_____) Convulsive Disorder	(_____) Tuberculosis	(_____) Foods *(Specify)*
(_____) Allergies *(Specify)*	(_____) Vision	(_____) Insect Bites
(_____) OTHER *(Specify)*	(_____) Hearing	(_____) OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS	AGE IT BEGAN	TREATMENT/MEDICATIONS
(Long term or chronic)		
1.		
2.		
3.		
4.		
5.		

I, ____________________ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED ________________ DATE ________ RELATIONSHIP __________

Subscribed and sworn to before me this ____ day of ________ 20 ____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

PICK UP AUTHORIZATION

I (we) the parent(s) of ______________________________, give my (our) consent for the following individual(s) to pick up my (our) child if I (we) cannot to do so.

Name	Address	Phone#

The following individual(s) are not allowed to pick up my (our) child.

1. ______________________________

2. ______________________________

____
Parent(s) signature

____
Date

____
Providers' signature

____
Date

Pear Tree Explorers
Nursery &
Pre-School

TRANSPORTATION AGREEMENT

Pear Tree Explorers
Nursery &
Pre-School

I give _______________________________ my
(PROVIDERS' NAME, DRIVERS' NAME)

permission to transport my child

_____________________ by ____________, to and
(CHILDS' NAME) (VAN, CAR, BUS)

from school, home, etc.

_____________________________ _______________
Parent(s) signature **Date**

_____________________________ _______________
Providers' signature **Date**

FEEDING SCHEDULE

FOR ______________________________, DOB: ____________________,
(Child's Name)

I ____
(Parent's Name)

☐ Will Supply ______________________, with _____ bottles of prepared
(Provider's Name)

______________________________ formula, to be fed _____ times a day.
(Name of Formula)

☐ Give permission to the On-Site Provider to prepare ____________________
(Name of Formula)

formula, for _____ bottles per day, to be fed _____ times a day.

☐ Will also provide:

_____ Bottle/s of water, to be fed _____ times a day,
_____ Bottle/s of juice, to be fed _____ times a day,
_____ Yogurt, to be fed _____ times a day,
_____ Puree fruit, to be fed _____ times a day,
_____ Cereal, to be fed _____ times a day by spoon.

Additional Notes:

____

____

____

____

____

Pear Tree Explorers Nursery & Pre-School

Parent's Signature:

Signature: ______________________________ Date: ______________

SLEEPING AND NAPPING AGREEMENT
Family Day Care and Group Family Day Care

Sleeping and napping arrangements must be made in writing between the parent and the child care provider. The provider shall maintain this completed agreement on file in the child care home. This arrangement is required by New York State Child Day Care Regulations [Family Day Care 417.7 (i) and 417.8 (a) (1), and Group Family Day Care 416.7 (i) and 416.8 (a) (1)].

I, (parent name) ____ , understand that my child(ren),

__________________________, while under the care of (child care provider)

____, will be napping on a (bed/cot/mat/chair)

________________________________ in the (baby room/main room)______________________________ of the child care home.

My napping child will have competent supervision at all times, either through:

(Please check one box below)

□ Direct supervision by a caregiver who is in the same room and has direct visual contact with him/her;

OR

□ Indirect supervision by a caregiver who uses a functioning electronic monitor and remains on the same floor as my child at all times. The doors to all rooms where children are napping must remain open, as well as the doors to all rooms used by the provider.

If my child is an infant, I also understand that my child will be placed on his/her back to sleep.

Parent's Signature:

Name (please print): _____________________________ Signature: ____________________________________

Date: ____ (Month/Day/Year)

Child Care Provider's Signature:

Name (please print): _____________________________ Signature: ____________________________________

Date: ____ (Month/Day/Year)

OUTDOOR ACTIVITY PERMISSION FORM

The provider and staff of_____________________________ may take my child ____________________for short walking trips and any of the activities checked below as part of the Family/Group Family Day Care Program.

( ) Providers' Backyard
( ) Neighborhood Park
( ) Other: _________________

_____________________________ ________________
Parent/Guardian signature **Date**

Pear Tree Explorers
Nursery &
Pre-School

WEEKLY CHILD CARE SCHEDULE

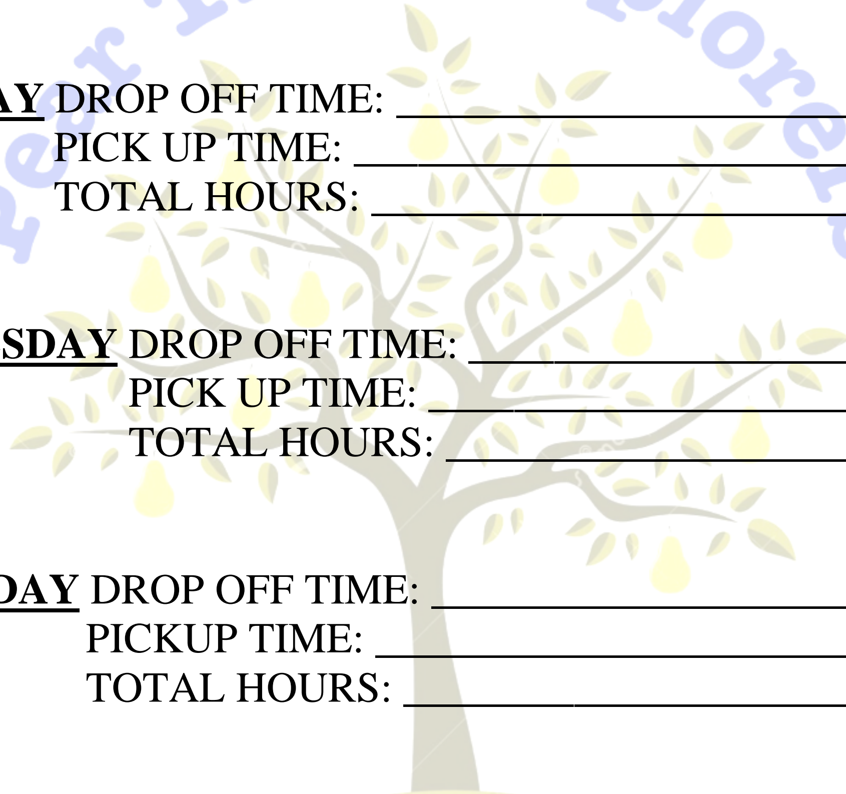
1. **MONDAY** DROP OFF TIME: ____________________________
   PICK UP TIME: ______________________________
   TOTAL HOURS: _____________________________

2. **TUESDAY** DROP OFF TIME: ____________________________
   PICK UP TIME: ______________________________
   TOTAL HOURS: _____________________________

3. **WEDNESDAY** DROP OFF TIME: _______________________
   PICK UP TIME: __________________________
   TOTAL HOURS: ________________________

4. **THURSDAY** DROP OFF TIME: __________________________
   PICKUP TIME: _____________________________
   TOTAL HOURS: ___________________________

5. **FRIDAY** DROP OFF TIME: _____________________________
   PICK UP TIME: _______________________________
   TOTAL HOURS: ______________________________



TOTAL WEEKLY HOURS OF CHILD CARE: __________________

EMERGENCY CONTACTS

In case of an emergency please use the following information listed below to contact the parents, family members or close friends of my children or child ______________________________.

Mothers Name: ________________________

Job: ______________________________

Cell: _____________________________

Home: ____________________________

Fathers Name: ________________________

Job: ______________________________

Cell: _____________________________

Home: ____________________________

Doctor's Name: ________________________

Doctor's Number: ______________________

Contact (1) Name: _____________________

Contact (2) Name: _____________________

Contact (3) Name: _____________________

Pear Tree Explorers
Nursery & Pre-School

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e., air/skin contact/ingestion, etc.***):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

What Your Full Time Enrollment Includes

1. **Affordable Childcare**
   Weekly Tuition Due by 6pm on the Preceding Friday of the Week of Childcare.
   (Unless otherwise advised)

2. **Parent and Provider Partnership:**
- Full Disclosure to **Parents** About Incidents or Illnesses Observed
- Full Disclosure to **Childcare Provider** About Incidents or Illnesses Observed

3. **Group Childcare.**
   - Understanding that your child will be in the presence of other children.
   - Understanding that we encourage and guide our children to grow and become independent.
   - We encourage social interactions with children and staff.

4. **Peace of Mind (For Parents)**
   Safe, Healthy and Fun Learning Environment (For Children)
- We communicate when we have a need for supplies, when we have questions, and we provide feedback when necessary.
- Since safety is our priority, we ask that you utilize the Parent Handbook for questions so that we can remain focused on our daily tasks.

5. **Updates on Status of Child's Development and Progress**
- For Infants (Up to Age 6 Months): Daily Log with Diaper, Nap, Bottle, Feeding Times and Observations
- Progress Reports with CDC's Developmental Milestones for infants, toddlers and preschoolers
- Scheduled Meetings Via Phone or In-person

6. **Intimate Childcare Setting**
   - We provide a nurturing environment that encourages our children to be confident and supported.
   - Everyone knows one another well and children develop healthy bonds as friends.

7. **Parent Handbook**
   - Policies & Procedures
   - Website for information (PEARTREEEXPLORERS.COM)

8. **Meals**
   - We supply meals for children who are ready to eat table food.
   - When a parent has a dietary preference, we ask that you provide your child's meals.
   - When a child has a food allergy, we ask that you make us aware as soon as possible. We also ask that you provide your child's meals as we will not serve food to a child with food allergies.

9. **Potty Training Assistance**
   - With cooperation from parents, we will assist in the potty-training process.
   - All children must be potty trained by 3 years old.

10. **Electronic Weekly Invoices (& Paid Invoices)**

Pear Tree Explorers Nurcery & Pre School

By signing this form, I accept and agree to the above listed expectations as a parent of a child at Pear Tree Explorers Home Child Care, Inc.

Parent's Signature: ____

Parent's Name Printed: ____

Date: ___________________