

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
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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 Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	

b. Name and Relationship to Child

Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	

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.
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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.
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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.
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PHYSICIAN OR MEDICAL FACILITY

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

Signature	Date Signed
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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. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) 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)	Address – Home (Street, City, State, Zip Code)		
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)	

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

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child. <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen. <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child. <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength
	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.

- | | |
|---|--|
| <input type="checkbox"/> No specific medical condition | <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism |
| <input type="checkbox"/> Cerebral palsy / motor disorder | |
| <input type="checkbox"/> 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.

DAY CARE IMMUNIZATION RECORD

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

PERSONAL DATA

PLEASE PRINT

STEP 1

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

IMMUNIZATION HISTORY

STEP 2

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					Second Dose					Third Dose					Fourth Dose					Fifth Dose									
	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTap, or DT)																														
Polio																														
Hib (Haemophilus influenzae Type B)																														
Pneumococcal Conjugate Vaccine (PCV)																														
Hepatitis B																														
Hepatitis B																														
Measles-Mumps-Rubella (MMR)																														
Varicella (chickenpox) vaccine																														
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 _____
 No or Unsure (Vaccine is required) (Vaccine is not required)

REQUIREMENTS

STEP 3

The following are the minimum required immunizations for the child's age/grade level while attending this day care must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day 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 3 PCV 2 Hep B 1 MMR 1 Varicella
2 years through 4 years	4 DTP/DTap/DT 3 Polio 3 Hib 3 PCV 3 Hep B 1 MMR 1 Varicella
At Kindergarten entrance	4 DTP/DTap/DT 4 Polio 3 Hib 3 PCV 3 Hep B 2 MMR 2 Varicella

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).

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.

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). 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).

COMPLIANCE DATA AND WAIVERS

STEP 4

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

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 day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day 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)

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):

SIGNATURE

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

STEP 5

SIGNATURE _____
 Date Signed _____
 SIGNATURE - Parent, Guardian or Legal Custodian

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* 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: _____