Divine Miniature Moments Day Care

Child's Name ______________________

900 Asbury Trail
Lithonia GA 30058
470-295-3316/fax 770-755-5830

FAMILY CHILD CARE LEARNING HOME
CHILDREN'S ENROLLMENT RECORD

CHILD'S INFORMATION

Child's Full Name:		**Child Resides with:**
Nickname:		
Date of Birth:		**Child's Age:**
Child's Home Address: (Include Number and Street Name)		
City/State/Zip:		

OTHERS AUTHORIZED TO PICK UP CHILD FROM FAMILY CHILD CARE LEARNING HOME

For your child's safety, I only allow children to leave my home with you (the person enrolling the child) and the person(s) you have specified below (One person should be listed that is not a parent/guardian). Changes to this list must be made in writing.

Name:		**Name:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Telephone:		**Telephone:**	
Relationship to child & guardian:		**Relationship to child & guardian:**	

PARENT(S)/GUARDIAN(S) INFORMATION

	Mother	Father
Name:		
Home Address:		
City/State/Zip:		
Home Telephone:		
Cell Telephone:		
Pager Number:		

PARENT(S)/GUARDIAN(S) WORK INFORMATION

Mother's Employer:	
Work Telephone:	
Work Address:	
City/State/Zip:	
Father's Employer:	
Work Telephone:	
Work Address:	
City/State/Zip:	

SPECIAL INSTRUCTIONS TO CONTACT PARENTS:

OTHER EMERGENCY CONTACT INFORMATION

In case of illness or other emergency, give the name, address and telephone number of nearest relative or friend who can be contacted if the parents cannot be reached.

Name:	
Relationship to Child:	**Grandparent Aunt/Uncle Sister/Brother Friend**
Address: **(Include Number and Street Name)**	
City/State/Zip:	
Telephone:	
CHILD'S PEDIATRICION OR PRIMARY SOURCE OF HEALTH CARE	
Name of Physician:	
Telephone:	
Address: **(Include Number and Street Name)**	
City/State/Zip:	

MEDICAL EMERGENCY STATEMENT

I hereby give ______________________________(Name of Family Child Care Provider) permission to take my child, ____________________________, to a hospital for medical treatment when I cannot be reached.

______________________ ______________________

Parent Signature **Date Signed**

Note: Many emergency services personnel often require notarized authorization in order to proceed with care. Please request from your provider and complete a **MEDICAL CARE AND EMERGENCY CONTACT INFORMATION** form in order to provide this detailed information.

PERMISSION TO TAKE THE CHILD OFF THE PREMISES

I hereby give ______________________________(Name of Family Child Care Provider) permission to take my child, ____________________________, on excursions from the family day care home that might include the following types of activities:

____

____

____

(The provider should fill in the above list with activities that she might provide away from home. Examples might include trips to the store, riding in the car, swimming, etc.)

Parent/Guardian ______________________ **Date** ______________

DIVINE MINIATURE MOMENTS DAY CARE

CONTRACT AND RATE AGREEMENT

Enrollment Date: ____________________

This contract is effective ___/____/____, it is an agreement between: ________________________________, and Tammy Geter D/B/A Divine Miniature Moments Day Care for the care of the children listed below:

We (I) ____have received and read Divine Miniature Moments Day Care Handbook of Policies & Procedures and hereby agree to comply with all the provision contained therein, and shall at this time enter into agreement with Tammy Geter D/B/A Divine Miniature Moments Day Care for the care my child (ren).

Full Name_______________________________________D.O.B.____________________

Full Name_______________________________________D.O.B.____________________

Full Name_______________________________________D.O.B.____________________

Full Name_______________________________________D.O.B.____________________

A rate of $________will be charged for full time or part time child (ren). This rate is per week (day/hour) per child (ren). This rate will be charged regardless of my child's attendance and are due at or before drop off time on my first contracted day of care and Monday of each week.

I understand that I will be billed a late fee of $5.00 (due at time of pick up) if I pick up after day care is closed and $1.00 per minute per child thereafter. My contracted days and hours are as follows:

Monday ________________AM/PM to __________________AM/PM

Tuesday________________AM/PM to __________________AM/PM

Wednesday_____________AM/PM to __________________AM/PM

Thursday_______________AM/PM to __________________AM/PM

Friday__________________AM/PM to_________________AM/PM

Additional Agreements______________________________________

____

______________________________ ____________________
Parent/Guardian Signature Date

______________________________ ____________________
Parent/Guardian Signature Date

______________________________ ____________________
Provider Signature Date

DIVINE MOMENTS DAY CARE
Tammy Geter
900 Asbury Trail
Lithonia GA 30058

Infant Feeding Plan

Family Child Care Rule: 290-2-3.10(4)

The provider shall secure from the parents infant formula and feeding plan for children under 1 year of age.

Child's Name ____________ Child's Birthday ____________ Date Plan Completed ____________

Does your child take a bottle? ☐ Yes ☐ No
Is the bottle labeled? ☐Yes ☐ No (with child's name)
Is the bottle warmed? ☐ Yes ☐ No
Does the child hold own bottle? ☐ Yes ☐ No
Can the child feed self? ☐ Yes ☐ No

Does your child eat: (check all that apply)
☐Strained foods ☐Formula
☐Baby foods ☐Whole Milk
☐Table foods ☐Other: ____________

What type of formula is used? ____________

Amount of formula to be given: ____________

Updated amounts of formula: ____________ Date: ____________
____________ Date: ____________
____________ Date: ____________

Instructions for the introduction of solid foods: ____________

Food likes:

Food dislikes:

Does child take a pacifier? 0Yes 0No If yes, when? ____________

Does your child have Allergies/Known Medical Conditions (Include any premixed formula)? 0 Yes 0 No

If yes, please list: ____________

Your child will be placed on back to sleep per SIDS rules unless written doctor's statement is provided.

CHILD'S SCHEDULE

Breakfast

____________ (approximate time) ____________ Type and approximate amount of food

Lunch

____________ (approximate time) ____________ Type and approximate amount of food

Dinner

____________ (approximate time) ____________ Type and approximate amount of food

Morning Nap ____________ (approximate time)

Afternoon Nap ____________ (approximate time)

Infant feeding plan needs to be updated every three months, or as needed, in regards to adding new foods or other dietary changes with a new parent/guardian signature and date:

____________ Parent/Guardian Signature ____________ Date

Infant Affidavit

Name of Sponsor (if applicable) ______________________________

Name of Provider/Center ______________________________

Name of Infant: ______________________

Infant Date of Birth: ______________________

Name of Parent/Guardian:

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: ______________
Center/provider will provide the following Iron-fortified infant cereal: ______________
Center/provider will provide the following brand of infant foods: ______________

Parents/Guardians,

Please check one of the following options below and sign this form:

_______ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

_______ I will provide the following meal component to my infant and the center will provide all other meal components:

- ☐ Formula*
- ☐ Cereal
- ☐ Fruit
- ☐ Vegetable
- ☐ Meat/Fish/Poultry/Eggs/Beans/Peas
- ☐ Cheese/Cottage Cheese/Yogurt
- ☐ Bread/Crackers/Breakfast Cereal

______________________________ ______________

Parent/Guardian Signature Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

INFANT FEEDING PLAN

Child's full name______________________________ Date______________

Date of birth______________________________

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? ______________________________

Amount of formula/breast milk to be given? ______________________________

Updated amounts of formula/breast milk: ______________ Date: ______________
Amount: ______________________________ Date: ______________
Amount: ______________________________ Date: ______________
Amount: ______________________________ Date: ______________
Amount: ______________________________ Date: ______________

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?______________________________

____

Food likes ______________________________

Dislikes ______________________________

Allergies? (Include any premixed formula)______________________________

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods______________________________

____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. ______________

____

____

PARENTS' SIGNATURE: ______________________________ **Date:** ______________

DECAL SAMPLE

Safe Sleep Practices Policy

Child's name:______________________________ Date of birth:___________________

Parent/Guardian name:____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

____

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature__________________________________ Date_______________

Parent/Guardian Notice of No Liability Insurance and Acknowledgment

(Only Complete this Form if Instructed by your Child Care Provider)

I understand I am being informed in writing by signing this acknowledgment that this child care facility does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

Parents'/Guardians' Signature(s):

_______________________________ Date: ______________

_______________________________ Date: ______________

Printed Name(s):

____

____

Per SB 24 (2004) requiring child care facility owners who are not covered by liability insurance to **provide and retain written notice** regarding no coverage to the parents and guardians.

Child Enrollment Form for the Child and Adult Care Food Program
Family Day Care Home

CHILD(REN)'S INFORMATION:

Child's Name (1) ____________________ Date of Birth ___/___/___ (Month Day Year)

Child's Name (2) ____________________ Date of Birth ___/___/___ (Month Day Year)

Home Address ____________________ *Home Phone* ____________________

Normal Days of Care with the Provider: __S __M __T __W __TH __F __S Check if Parent works multiple shifts

Normal Hours of Care with the Provider: ____________ AM ____________ PM

Meal Participation with the Provider ____Breakfast ____Snack (AM) ____Lunch ____Snack (PM) ____Supper

SCHOOL INFORMATION:

School/Child Care Center (1) ____________________ Grade (1) ____________

School/Child Care Center (2) ____________________ Grade (2) ____________

My child(ren) participate(s) in the following meals at school, Head Start center, or child care center:
[ ] Breakfast [ ] AM Snack [ ] Lunch [ ] PM Snack [ ] Supper

PARENTAL INFORMATION:

Mother's Name ____________________ Work Hours ____________
Work Name & Address ____________________ Work Phone ____________
____________________ Home Phone ____________

Father's Name ____________________ Work Hours ____________
Work Name & Address ____________________ Work Phone ____________
____________________ Home Phone ____________

Are there any unusual guardianship or custodial relationships? ____________________

Persons authorized to pick up child(ren) ____________________
Special Needs of Child (1) ____________________
Medical Information (allergy, sickness, etc.)(1) ____________________
Special Needs of Child (2) ____________________
Medical Information (allergy, sickness, etc.)(2) ____________________
In case of injury of accident ____________ ____________ ____________
Physician's Name *Physician's Phone* *Hospital of Choice*

I hereby give permission to treat my child(ren) in case of medical emergency.

____________ ____________ ____________
Parent's Signature *Parent's Signature* *Date*

NAMES OF TWO OTHER PERSONS THAT CAN BE CONTACTED IN CASE OF EMERGENCY

Name ____________	Name ____________
Address ____________	Address ____________
Phone ____________	Phone ____________

My child (1) is: [ ] Related to Provider: Relationship____________ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

My child (2) is: [ ] Related to Provider: Relationship____________ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

I understand that my provider has applied to receive federal funds for meals served to my child(ren) and that I may be contacted to verify my child(ren)'s attendance. I have attached current immunization record(s) for my child(ren).

Child's Age (1) ______ Enrollment Date (1) ____________ Withdrawal Date (1) ____________
Reason for Withdrawal ____________

Child's Age (2) ______ Enrollment Date (2) ____________ Withdrawal Date (2) ____________
Reason for Withdrawal ____________

NOTE: Providers MUST retain emergency contact information for every child. Sponsors should retain a copy of this form to validate enrollment.

Revised 2/2005
CACFP
FSFA