

REGISTRATION AGREEMENT

CREEK DAY SCHOOL, INC.

2509 McDivitt Rd.
Madison, WI 53713

- 1. There will be a one month trial period. If a situation of concern develops (i.e., discipline or adjustment problem) a conference will be arranged between parent(s) and staff.
- 2. I understand that I must give a two week notice prior to withdrawing my child from school; penalty for immediate withdrawal will be paying two weeks additional tuition.
- 3. I understand that I am contracting for a minimum number of days per week and that I am obligated to pay the weekly fee even if my child should be absent. I understand this includes absence due to sickness, holidays, snow days and scheduled in-service days. If Madison Public Schools are closed for inclement weather, Creek Day School will also be closed.
- 4. I understand that fees are to be paid one week in advance. If I should fall two weeks behind I will be asked to withdraw my child. If I should foresee financial difficulty I will discuss the matter with the Director. I understand that I am responsible for the fees irregardless of third party payments from other sources.
- 5. I understand there is a \$35.00 non-refundable enrollment fee to be paid prior to the first day of attendance and upon re-enrollment.

A commitment fee of _____ is a down payment for future enrollment. This fee will be applied to the first week's attendance. It is non-refundable.

Parents who wish to withdraw their children for a time period of more than 4 weeks can pay a fee equal to one week's tuition to reserve a space for their return.

- 6. I understand that my tuition will be \$ _____ per week. Schedule: _____.

Five hours per year of volunteer service is required as a condition of enrollment in Creek's program. In lieu of volunteer time, an annual fee of \$30.00 can be paid, due upon enrollment, and annually thereafter. Please indicate which option you choose:

_____ I will perform 5 hours of volunteer service at Creek Day School annually. Services may include: attendance at work days, assisting in the classroom at lunch or on field trips, performing maintenance duties as needed, clerical work as needed, participation in fundraisers, serving on the Board of Directors, or other duties as needed.

_____ I will pay the annual fee of \$30.00 in lieu of volunteer service.

- 7. I understand that the day care center's hours are 7:00 a.m. to 5:30 p.m. and that I am responsible for paying \$1.00 per minute for the time which my child remains in the care of center staff after 5:30 p.m. The late fee will be billed and is due within 5 days of receipt.
- 8. In the event of absence, for any reason, I shall notify the day care center staff (271-1921) and I am responsible for my child's tuition payment.

9. The day care staff will assume full responsibility for my child while the child is at school. The school is not responsible for children enroute to/from school.
10. I give permission for my child to participate in field trips planned by center staff.
11. _____ I give permission for the staff to apply sunscreen to my child before outside play during the summer.
 _____ I give permission for the staff to apply insect repellent to my child before outside play when needed.
12. Publicity: From time to time photographs or video tapes may be taken of the children at Creek for use in educational presentations or for publicity. I give permission for my child's image to be used:
 _____ YES _____ NO (please indicate)
14. I understand that Creek Day School, Inc. is a not-for-profit corporation run by a Board of Directors, that the Board includes parents and community members. Any parent is eligible to become a member of the Board. Elections are held annually. I shall notify the Director if I am interested.
15. I understand that the agents of the corporation shall be held harmless, jointly or individually, from any actions brought against Creek Day School, Inc.
16. If a medical emergency arises, the staff will first attempt to notify the parent/guardian. If they are not reachable, the emergency contact will be notified. In the event of an emergency requiring immediate medical attention, the ambulance (911) will be called for transport (at the parent/guardian's expense) to the hospital of choice as indicated on the child's enrollment form.

I agree to adhere to the registration policies of Creek Day School, Inc. and give my child,

_____ permission to participate fully in this program.

 Parent(s) Signature

Date _____

 Director's Signature

Date _____

DAY CARE CHILD ENROLLMENT AND HEALTH HISTORY

Use of form: This form is to be utilized by Group Day Care Centers, Family Day Care Centers, Day Camps for Children and Certified Day Care Homes to collect critical information on children being enrolled. Licensed Family/Group Day Care Providers: When enrolling a child under 2 years of age, attach completed "Day Care Intake for Child Under 2 Years" (CFS-61).

CHILD INFORMATION

| | | | | |
|------------------------|---|------------------|----------------------------|-------------------------|
| Name (Last, First, MI) | Address - Home (Street, City, State, Zip) | Telephone Number | Birthdate (mm / dd / yyyy) | First Day of Attendance |
|------------------------|---|------------------|----------------------------|-------------------------|

PARENT OR GUARDIAN - The parents or guardian are permitted to visit during center hours unless access is prohibited or restricted by a court order. Attach court order, if any.

| Relationship to Child | Name | Home Address | Telephone Number | Address Where Reachable When Child is at Facility | Telephone Number |
|-----------------------|------|--------------|------------------|---|------------------|
| Mother | | | | | |
| Father | | | | | |
| Guardian | | | | | |

PERSONS AUTHORIZED TO PICK UP YOUR CHILD

| Relationship to Child | Name | Home Address | Telephone Number | Address Where Reachable When Child is at Facility | Telephone Number |
|-----------------------|------|--------------|------------------|---|------------------|
| | | | | | |
| | | | | | |

EMERGENCY CONTACT - Person to contact when mother, father or guardian cannot be reached.

| Relationship to Child | Name | Home Address | Telephone Number | Address Where Reachable When Child is at Facility | Telephone Number |
|-----------------------|------|--------------|------------------|---|------------------|
| | | | | | |

PHYSICIAN OR MEDICAL FACILITY

| Name | Address | Telephone Number |
|------|---------|------------------|
| | | |

AUTHORIZATION

- 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 day care center and a summary of the Wisconsin Rules for Licensing Day Care Centers.
 Yes No I give permission for my child to participate in field trips and other activities during operating hours. Transported Walking

SIGNATURE - Parent or Guardian

| |
|-------------|
| Date Signed |
|-------------|

HEALTH HISTORY

1. Serious illnesses child has had within the last six months - List

2. Child has allergies such as bee stings, food or medications? Yes No
If "Yes" - Describe. Indicate special precautions or care needed.

3. Indicate whether child has a history of:

- disabilities such as physical, sensory or cognitive
- asthma
- heart problems
- rheumatic fever
- seizures
- other conditions - specify:

4. Special emergency care instructions or other information needed by child care staff/provider - Describe

SIGNATURE - Parent or Guardian

Date Signed

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 within **30 school days (6 calendar weeks) of 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) | 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) | |

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 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 <i>Influenzae</i> 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)

REQUIREMENTS

STEP 3 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 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 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 Polio | | | 3 Hep B | 2 MMR ³ | 2 Varicella |

¹If 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).

²If 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.

³MMR 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).

⁴Children 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

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

 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):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

 SIGNATURE - Parent, Guardian or Legal Custodian

 Date Signed

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is mandatory to comply with DCF 250.07(6)(L)3. and DCF 251.07(6)(k)3. It also meets the requirements of DCF 202.08(4). Failure to comply may result in issuance of a noncompliance statement. Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules.

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 after admission. Except for a school-aged child, each child 2 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 after admission.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)

Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

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

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify.

Date of 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 HealthCheck Provider (type or print)

Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider

Date of Examination



Parent/Guardian Instructions:

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. This form can be used for three years for the same child, to meet the annual updating requirements.

GENERAL INFORMATION

| | | |
|--------------|---------------------|-------------|
| Child's Name | Child Care Facility | Child's Age |
|--------------|---------------------|-------------|

HOURS AND MEALS WHILE IN CARE

| Days Normally in Care (Check <input type="checkbox"/>) | Hours Normally in Care | | | | Meals Normally Received While in Care (check <input type="checkbox"/>) | | | | | |
|---|------------------------|----|------|----|---|----------|-------|----------|--------|---------------|
| | From | To | From | To | Breakfast | AM Snack | Lunch | PM Snack | Supper | Evening Snack |
| Sunday <input type="checkbox"/> | | | | | | | | | | |
| Monday <input type="checkbox"/> | | | | | | | | | | |
| Tuesday <input type="checkbox"/> | | | | | | | | | | |
| Wednesday <input type="checkbox"/> | | | | | | | | | | |
| Thursday <input type="checkbox"/> | | | | | | | | | | |
| Friday <input type="checkbox"/> | | | | | | | | | | |
| Saturday <input type="checkbox"/> | | | | | | | | | | |

Additional Information

parent contact phone number:

| | |
|------------------------------|-------------|
| Signature of Parent/Guardian | Date Signed |
|------------------------------|-------------|

ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

| | |
|------------------------------|-------------|
| Signature of Parent/Guardian | Date Signed |
|------------------------------|-------------|

ANNUAL UPDATE 2

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

| | |
|------------------------------|-------------|
| Signature of Parent/Guardian | Date Signed |
|------------------------------|-------------|

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, age, sex, and disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.