# Family Information Sheet

TRINITY
Early Learning Center

**Child's Full Name** _____ Date of Birth _____

**Child's Full Name** _____ Date of Birth _____

**Parent's Name:** _____ Date of Birth: _____
Email Address _____ ☐ Lives with ☐ Emergency Contact ☐Pick up
Street Address_____ City, State, Zip _____
Phone Number (listed in order to call)_____ ☐ Mobile ☐Work ☐Home
Phone Number _____ ☐ Mobile ☐ Work ☐Home
Phone Number _____ ☐ Mobile ☐ Work ☐Home
Employer _____ Position
_____ Faith Preference (optional; does not affect enrollment)
☐ None ☐ I describe myself as _____ Home Church (if applies) _____

**Parent's Name**_____ Date of Birth and Age_____
Email Address _____ ☐ Lives with ☐ Emergency Contact ☐Pick up
Street Address_____ City, State, Zip _____
Phone Number (listed in order to call)_____ ☐Mobile ☐Work ☐Home
Phone Number _____ ☐ Mobile ☐Work ☐Home
Phone Number _____ ☐ Mobile ☐Work ☐Home
Employer _____ Position _____
Faith Preference (optional; does not affect enrollment)
☐None ☐I describe myself as _____ Home Church (if applies) _____

Who else is living with you and your child(ren)?_____

Insurance Provider_____ Phone Number _____
Policy Number _____ Group Number _____

Family Physician's Name_____ Phone Number _____
Street Address _____ City, State, Zip _____

Family Dentist's Name_____ Phone Number _____
Street Address _____ City, State, Zip _____

Case Worker or Service Provider_____ Phone Number _____
☐DHS ☐EI ☐MECP ☐Other_____

By signing this form you are stating that this information is true and current. You are also stating that you have viewed the Family Information Board by the front office with the current license, menu, closure days, etc.

_____ _____
Signature of Parent /Guardian Date

_____ _____
Signature of Parent /Guardian (Re-Enrollment) Date (Re-Enrollment)

_____ _____
Signature of Parent /Guardian (Re-Enrollment) Date (Re-Enrollment)

# Release Form

## PARENTS' HANDBOOK

I, _____, the parent or legal guardian, have received a Parents' Handbook and agree to abide by its policies. I have also reviewed and acknowledged the license (located outside of the front office) of Trinity Early Learning Center.

_____ _____

Signature of Parent /Guardian Date

## CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILD

I, _____, the parent or legal guardian hereby give permission that my child, _____, may be given emergency treatment to include first aid and CPR by a qualified staff member of Trinity Early Learning Center. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by my child's regular physician or when the physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. In such a case, I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I agree that I will pay all physicians and hospital bills and that TELC shall not be responsible for them.

_____ _____

Signature of Parent /Guardian Date

_____ _____

Signature of Parent /Guardian (Re-Enrollment) Date (Re-Enrollment)

_____ _____

Signature of Parent /Guardian (Re-Enrollment) Date (Re-Enrollment)

## EMERGENCY CONTACTS AND CONSENT TO RELEASE

Other than to the parent or guardians, my child will only be released to persons indicated below. At least two local persons must be listed to call in case of illness, accident, late pick-up, or other reasons. *Please list in order of contact preference* and alert those listed to bring photo identification. All contacts you approve must be listed, regardless if they have been listed in previous years. If a name is not listed, it is assumed they are no longer authorized.

Name & Relationship to Child: Contact number:

_____ Date of Birth _____ _____

☐ Emergency Contact ☐ Pick up ☐ Mobile ☐ Work ☐ Home

_____ Date of Birth _____ _____

☐ Emergency Contact ☐ Pick up ☐ Mobile ☐ Work ☐ Home

_____ Date of Birth _____ _____

☐ Emergency Contact ☐ Pick up ☐ Mobile ☐ Work ☐ Home

_____ Date of Birth _____ _____

☐ Emergency Contact ☐ Pick up ☐ Mobile ☐ Work ☐ Home

My child should **NEVER** be released to the persons listed below. If there is a court order or other legal paperwork that could assist law enforcement, please provide a copy for us to keep on file.

_____

_____

Signature of Parent /Guardian Date

TRINITY
Early Learning Center

# Schedule Request

**Account Name** _____

**Child's Name** _____

**Child's Birthday** _____

**Date change will be effective (if approved)** _____

30 days' notice is required for your requested schedule change. We review schedule change requests twice a month, at the 1st of the month and after the 15th. If your request misses one of those reviews, your request will be considered at the next review.

If we cannot approve your request by the date you prefer, we will continue to review your request while we still hold it. If we have an unexpected opening between reviews, we can approve your request and your child's new schedule can begin immediately. Please withdraw your request if your plans change.

*Please list all days of your preferred schedule (including days you already use).*

| | **Drop Off Time** | **Pick up Time** |
|---|---|---|
| **Monday** | _____ AM/ PM (circle one) | _____ AM/ PM (circle one) |
| **Tuesday** | _____ AM/ PM (circle one) | _____ AM/ PM (circle one) |
| **Wednesday** | _____ AM/ PM (circle one) | _____ AM/ PM (circle one) |
| **Thursday** | _____ AM/ PM (circle one) | _____ AM/ PM (circle one) |
| **Friday** | _____ AM/ PM (circle one) | _____ AM/ PM (circle one) |

I understand that adding days to my child's schedule may require a tuition increase. Mid-month tuition changes will be prorated. I approve your charging my on-file credit card before the new schedule begins.

I understand that reducing days from my child's schedule may result in a tuition credit. Mid-month tuition changes will be prorated. I approve your keeping my credit on account where it will be applied to next month's tuition.

_____ _____

Parent's Signature Date

For office use

New monthly payment amount $_____

Amount due at this time $_____

**For Office Use:**

☐ Master Roster ☐ Contract Billing

_____ _____

Director Date

☐ Printed ☐ Schedule ☐ Parent Confirmation

_____ _____

Office Manager Date

# Medication Request & Release

TRINITY
Early Learning Center

**Account Name** _____

**Child's Name** _____

| Name of Medication | Dosage/ Directions | Reason for Medication | Possible side effects or reactions |
|---|---|---|---|
| *Ex: Desitin Diaper Cream* | *Apply thick layer as needed* | *Diaper Rash* | *None* |
| | | | |
| | | | |

Medication must be in its original container with directions for administering. Staff will follow label's directions.

**Additional instructions or exact time to be given** _____

_____

_____ _____

Parent's Signature Date

**MEDICATION LOG**

| Date | Time | Dosage | Staff signature |
|---|---|---|---|
| | AM<br>PM | | |
| | AM<br>PM | | |
| | AM<br>PM | | |
| | AM<br>PM | | |
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| | AM<br>PM | | |
| | AM<br>PM | | |

| Date | Time | Dosage | Staff signature |
|---|---|---|---|
| | AM<br>PM | | |
| | AM<br>PM | | |
| | AM<br>PM | | |
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| | AM<br>PM | | |
| | AM<br>PM | | |

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☐ My child has no allergies or preferences requiring substitutions

_____ Parent's initials _____ Date

# Allergies and Preferences

**Account Name** _____

**Child's Name** _____

**Completing this form VOIDS previous forms. You must re-write all allergies & preferences in their entirety. If previous entries are not listed, TELC assumes they are no longer current or necessary.**

**ALLERGIES to Food & Medicine** Be as specific possible and list specific foods, not food groups

| Food & Clarifications | Reaction to Expect | Step to take if accidentally ingested |
|---|---|---|
| (Example) Peanuts (other nuts ok) | Trouble breathing | Apply epi-pen immediately; see medication form |
| | | |
| | | |
| | | |

**PREFERENCES to avoid specific Foods/Drinks**

| Food & Clarifications | Reason for Preference |
|---|---|
| (Example) Vegan | Family Lifestyle |
| | |
| | |
| | |
| | |

I understand that it is my responsibility to provide **all food** on the days my child requires substitutions and that TELC will not provide food for any snacks or meals on a day that my child cannot partake of the entire days' menu. If milk alternatives are the only substitution, I will provide the alternative and TELC will provide foods according to the menu.

_____

Parent's Signature Date

## PARENTS' RESPONSIBILITY

1. **Review the menu daily**
2. **Provide ALL snacks and meals on a day my child requires food substitutions, no exceptions**
3. **Pack food with any needed ice packs or in a thermos *(TELC cannot refrigerate or heat foods from home)***
4. **Communicate to child's teacher where their food/lunch bag can be found (backpack, cubby, etc.)**

**For office use:**

Recorded in Brightwheel

☐ Tracking ☐ Dr. Note ☐ Medication Form ☐ Meds on site

☐ Printed for Classroom ☐ Printed for Kitchen ☐ Copied Form to Parent

_____

Signature from Office Date

# Let's get acquainted with your child

**Child's Name** _____ **Nickname** _____

**Child's Birthday** _____

Previously, my child was cared for by _____

I would say that my child's day was mostly structured/ unstructured? _____

Child's health history that might affect participation in class, current medical conditions, or current allergies?_____

_____

Does your child have any special needs? _____

_____

How do you describe your child? (Shy, friendly, assertive, energetic, sensitive, calm, fearless, serious, etc) _____

_____

Is there any specific family situation you would like your child's teacher to be aware of? _____

_____

_____

Does your child have specific fears or challenges? _____

_____

What is your child's ways of communicating their needs? _____

My child is usually comforted by _____

My child takes about ___ minutes to eat a full meal

In our family we ☐ Sit together and eat ☐ Eat at different times ☐ My child walks around while he/she eats

My child takes a ___ minute nap ___ times per day. Child's normal bedtime ___ PM ☐ Varies; no regular bedtime Can you give a few hints for putting your child down for a nap? (doll, special blanket, pacifier, etc.) _____

_____

Is there anything you would like us to know about your child?_____

_____

_____

_____

_____

# Student Information

It is a federal government requirement that TELC maintains records of the race and ethnicity of our student body, faculty, and staff. Thank you for your cooperation.

**Child's Full Name:** _____ Date of Birth: _____

**Child's Full Name:** _____ Date of Birth: _____

Ethnicity - Is the student Hispanic or Latino?

All persons of Latino, Hispanic, or Spanish origin (descended from a Central or South American, Mexican, Cuban, Puerto Rican, Dominican, or other Spanish-speaking country of origin, regardless of race or original language) should answer "Yes." All persons answering "Yes" to this first question will be recorded as Hispanic/Latino.

☐ Yes ☐ No

Race - Please mark all that apply.

Please mark at least one category. Those who choose more than one category will be reported as multiracial.

☐ American Indian or Alaska Native (A person having origins in any of the indigenous peoples of the continental U.S. or Alaska, Canada, Mexico, Central America, South America, or the Caribbean)

☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)

☐ Black or African American (A person having origins in any of the original peoples of the Black racial groups of Africa)

☐ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

☐ White (A person having origins in an of the original peoples of Europe, the Middle East, or North Africa)

# Oregon Certificate of Immunization Status
# Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Complete for all | Up-to-date | Medical | Non medical

| Child's Last Name<br>*Apellido* | First<br>*Primer Nombre* | Middle Initial<br>*Segundo Nombre* | Birthdate<br>*Fecha de Nacimiento* |
|---|---|---|---|
| Mailing Address<br>*Dirección* | City<br>*Ciudad* | State<br>*Estado* | Zip Code<br>*Codigo Postal* |
| Parents' or Guardians' Names<br>*Nombre de los padres o guardian* | | Home Telephone Number<br>*Número de Teléfono* | |

| **Vaccines** | **Dose 1** | **Dose 2** | **Dose 3** | **Dose 4** | **Dose 5** |
|---|---|---|---|---|---|
| Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td) | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) |
| Booster Dose Tdap | | | | | |
| Polio (IPV or OPV) | | | | | |
| Varicella (Chickenpox) [VZV or VAR]<br>☐ Check here if child has had chickenpox disease _____ (mm/dd/yy) | | | | | |
| Measles/Mumps/Rubella (MMR) | | | | | |
| ***or*** | | | | | |
| Measles vaccine only | | | | | |
| Mumps vaccine only | | | | | |
| Rubella vaccine only | | | | | |
| Hepatitis B (Hep B) | | | | | |
| Hepatitis A (Hep A) | | | | | |
| Haemophilus Influenzae Type B (Hib)<br>(Only children less than 5 years) | | | | | |

**I certify that the above information is an accurate record of this child's immunization history.**

Signature* _____ Date

Update Signature _____ Date

Update Signature _____ Date

Update Signature _____ Date

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

| **For school/facility use only** |
|---|
| School/facility Name |
| Student ID Number |
| Grade |

**Continued On Reverse Side**

# Oregon Certificate of Immunization Status, Page 2
# Oregon Health Authority, Immunization Program

Save

| Child's Last Name<br>*Apellido* | First<br>*Primer Nombre* | Middle Initial<br>*Segundo Nombre* | Birthdate<br>*Fecha de Nacimiento* |
|---|---|---|---|

**Recommended Vaccines**

| Recommended Vaccines | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|---|---|---|---|---|---|
| Pneumococcal (PCV)<br>(Only in children less than 5 years) | | | | | |
| Meningococcal (MCV4, MPSV4) | | | | | |
| Human Papilloma Virus (HPV)<br>(9 years or older) | | | | | |
| Influenza (Flu) | | | | | |
| Other Vaccine<br>Please specify: | | | | | |
| Other Vaccine<br>Please specify: | | | | | |

**For medical exemptions:**

**Please submit a *letter* signed by a licensed physician stating:**

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

**For Immunity Documentation** (history of disease or positive titer)**: Please submit a *letter* signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

**Nonmedical Exemption:**

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ A health care practitioner
- ☐ The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- ☐ Diphtheria/ Tetanus/Pertussis
- ☐ Polio
- ☐ Varicella
- ☐ Measles/Mumps/Rubella
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Hib

Signature of Parent or Guardian _____ Date _____

**Optional:**

ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

☐ Religious belief ☐ Philosophical belief ☐ Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____