STEPPING STONE

Start Date: _____

I would like this information to be effective:

☐ **Immediately**

☐ **September 2014**

Child Information

Please print using blue or black ink

Name of Child: _____ DOB _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Ethnic Origin: _____

Child Resides With: _____

FATHER/Legal Guardian's Name: _____ Cell: _____

Employer Name: _____ Work Phone: (___) _____

Home Address: _____ Home Phone: (___) _____

City: _____ State: _____ Zip: _____

Email: _____

MOTHER/Legal Guardian's Name: _____ Cell: _____

Employer Name: _____ Work Phone: (___) _____

Home Address: _____ Home Phone: (___) _____

City: _____ State: _____ Zip: _____

Email: _____

Emergency Contact Information:

Parents/guardians are automatically authorized to pick up and should not be included in this list. Emergency contacts must also be included on Authorized PU List & must be at least 18 years of age.

Primary <u>Local</u> Emergency Contact: Name _____

Relationship to Child: _____

Home Phone: (___) _____ Work Phone: (___) _____

Secondary <u>Local</u> Emergency Contact: Name _____

Relationship to Child: _____

Home Phone: (___) _____ Work Phone: (___) _____

<u>Out-of-Area (100+ miles)</u> Emergency/Disaster Contact: Name: _____

Relationship to Child: _____ City: _____

Home Phone: (___) _____ Work Phone: (___) _____

Persons <u>NOT</u> Authorized to Visit or Pick Up Student: _____

Persons not listed on the "Authorized to Pick Up" list nor given separate written permission will not be allowed to pick up your child. If special circumstances occur, such as a court-issued restraining order, please list the person(s)' name above & provide a copy of the order for your child's file.

ALLERGIES: _____

Child's Name: ______________________________________

Persons Authorized to Pick Up Student:

By state law, you must include **all emergency contacts (even out of area) as persons authorized to pick up. Parents are automatically authorized to pick up and **should not** be included in this list. All emergency contacts and persons authorized to pick up must be at least 18 years of age.*

Name:__________________________Relationship to Child:_________________
Address:____
City:_____________________________________State:________ Zip: _________
Home Phone: (_____)_________________Work Phone: (_____)____________
At least 18 years of age? _________

Name:__________________________Relationship to Child:_________________
Address:____
City:_____________________________________State:________ Zip: _________
Home Phone: (_____)_________________Work Phone: (_____)____________
At least 18 years of age? _________

Name:__________________________Relationship to Child:_________________
Address:____
City:_____________________________________State:________ Zip: _________
Home Phone: (_____)_________________Work Phone: (_____)____________
At least 18 years of age? _________

Name:__________________________Relationship to Child:_________________
Address:____
City:_____________________________________State:________ Zip: _________
Home Phone: (_____)_________________Work Phone: (_____)____________
At least 18 years of age? _________

Name:__________________________Relationship to Child:_________________
Address:____
City:_____________________________________State:________ Zip: _________
Home Phone: (_____)_________________Work Phone: (_____)____________
At least 18 years of age? _________

Child's Name: _____

Medical Information

Medical Insurance: Yes/No Insurance Company Name and ID#_____

Date of Last Doctor Visit: (Must Be Within One Year) _____

Doctor Name:_____Phone: (____)_____
Address:_____ City:_____ State:_____Zip:_____

Dentist Name:_____Phone: (____)_____
Address: _____City: _____ State:_____Zip:_____

Personal and Health History:

1. Type of Birth: Full Term_____Premature_____Natural_____Cesarean_____
2. Any Complications?_____
3. What is the birth order of your child?_____Who are the siblings?_____
   _____
4. Age child began: Sitting_____ Crawling_____ Walking_____ Talking_____
5. Any hospitalizations, operations, or serious illnesses?_____
   If yes, please explain: _____
6. Any serious accidents (broken bones, head injuries, falls, burns, poisoning) etc.?_____
   If yes, please explain: _____
7. Check any your child has or has had:

__Asthma	__Excessive Bleeding	__Speech Problems
__Diabetes	__Hearing Problems	__Strep Infections
__Ear Infections	__High Fevers	__Vision Problems
__Epilepsy	__Seizures	__Other

8. Any other health problems the Center should know about that would affect your child at school?_____
9. Is your child currently taking any medications? Please list all medication names and reasons:_____
10. Has your child been tested for or received speech therapy from public schools or other providers? Tested for hearing loss? Tested for vision loss? _____
    If yes, please explain: _____

11. Does your child have any allergies? _____
    (If yes, please also note on front page)
    a. Describe the reaction the child has:_____
    b. What is the treatment and/or medication?_____
12. An Individual Plan of Care (including instructions from parent or health care providers related to medications, specific food or feeding requirements, allergies, treatments, and special equipment or health care needs if necessary) is required when needed for chronic health conditions and life threatening medical conditions.

Does your child need an Individual Plan of Care? _____ (Y/N) See Center Director

Child's Name: _____

Family/Guardian Consent to Dispense Medication (Medication Provided by Family/Guardian)
Prescription or non-prescription medications will be dispensed only with prior **written** consent of the child's family/guardian. Unused mediation must be taken home by Friday of that week, or they will be thrown away. All medications must be in original containers labeled with child's name and dosage. If under 2 years old, all medications require a doctor's authorization.

The following non-prescription lotions and ointments may be applied according to recommended dosages: **Please Initial: Yes** *or* **No**

A. Diaper Area Medication: (Desitin, A&D Ointment, Vaseline) _____ _____
B. Outdoor Protection: NO-AD Sunblock, SPF UBA UBV 45 with Aloe & Vitamin E _____ _____
Children's 'Off' Insect Repellent _____ _____

Family/Guardian Signature:_____ Date:_____

Social and Developmental History:
1. What experiences has the child had playing with other children? _____
2. How does the child get along with others?_____
3. What method of behavior management is used at home?_____
4. What responsibilities does the child have at home?_____
5. What kinds of toys or activities does the child enjoy?_____
6. What is your family's religious affiliation? (*optional*) _____
7. Does the child and/or family attend church regularly? Where? (*optional*)_____
8. Is English your family's primary language? ☐ Yes ☐ No If no, which language is?_____
9. Please check all that apply:

__Shy	__Afraid	__Cries easily	__Sucks thumb
__Overactive	__Tantrums	__Runs away	__Picky eater
__Aggressive	__Toilet trained	__Writes name	__Buttons/zips
__Ties shoes	__Feeds self	__Climbs	__Rides trike/bike
__Brushes teeth	__Bathes self	__Dresses self	__Cuts w/scissors

Comments:

I learned about Stepping Stone Christian School and Child Care from:_____
_____

Family/Guardian Consent:

I hereby grant permission for my child:	**Please Initial**	**Yes** *or* **No**
1. To use all play equipment and participate in all activities of Stepping Stone.		_____ _____
2. To participate in supervised walks (if NO, please see Director).		_____ _____
3. To be transported in Stepping Stone van to and from Liberty Lake Elementary School and Central Valley Kindergarten Center (*School Age/Kindergarten)*		_____ _____
4. To use prints, slides, and videos of my child for educational and classroom purposes. Photos may be included in other children's educational portfolios.		_____ _____
5. To use prints, slides, and videos of my child for website, advertising, social media, or publicity purposes.		_____ _____
6. To be given emergency treatment (First Aid & CPR) by qualified staff. I further authorize and consent to medical, surgical, and hospital services to be performed for my child when unable to reach family/guardian.		_____ _____

- I have read and agree to comply with the policies and procedures of Stepping Stone as outlined in the current *Family Packet* (which contains the *Family Handbook*, *Health Care Plan*, and *Emergency Procedures*) and the *Rates and Financial Policies* document. I understand that policies and procedures may change and I will be notified of these changes.
- As part of the enrollment process, Stepping Stone staff discussed the Center's policies, procedures, philosophy, program, and facilities with me.
- My child's teacher will be the primary source of information concerning my child's progress.
- I have been encouraged to visit any time and to participate in Center activities.

Child's Name: _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ **Date:**_____

Relationship to Child: _____