ENROLLMENT CONTRACT

This agreement is made by and between MiniArt Family Home Daycare, LLC, Licensed Child Care Provider and _____, Parent/Guardian of _____.

The following has been agreed upon between the two parties beginning _____.

I have read and agree to full contents of the Parent's Handbook. I understand that disregarding these policies can result in termination from childcare enrollment. I understand that I must follow the termination policy as it is written in the Parent's Handbook.*

I agree to the weekly rate of $_____, for Full time☐Part Time☐*(circle one)* to be paid the Friday before the week begins for my child, _____. If Part-time, our attendance days will be _____.

Our arrival time will be _____, and pick up time will be no later than _____ from Monday-Friday / on our dates arranged above. Any added time before or after those times will be discussed beforehand, or will be subject to late pickup fees or early arrival fees.

This agreement shall be in effect until which time parent/guardian or provider has given termination notice in accordance to the Parent Handbook policy, or negotiation of a new contract.

THIS AGREEMENT AND THE PARENT HANDBOOK WHOLLY STATE THE OBLIGATIONS OF THE PROVIDER; THERE ARE NO OTHER IMPLIED OBLIGATIONS. ANY AMENDMENTS TO THIS AGREEMENT MUST BE IN WRITING AND SIGNED BY BOTH PARTIES.

_____ _____
Licensed Child Care Provider Date

BOTH PARENTS MUST SIGN OR PARENT/GAURDIAN WITH SOLE CUSTODY OF THE CHILD:

_____. _____ _____. _____
Parent/guardian Date Parent/guardian Date

*This will include late penalties, as stated in the policy, from date due to date paid, plus legal fees if applicable.

MEDIA RELEASE FORM

Date:

For good and valuable consideration, receipt of which is hereby acknowledged, I, the undersigned, hereby irrevocably consent to the unrestricted use by MINIART FAMILY HOME DAY CARE, LLC of my name, likeness, quotes from me, and information about me, for editorial purposes and/or for purposes of advertising or trade including, without limitation, for any and all MINIART FAMILY HOME DAY CARE, LLC advertising or promotional uses, throughout the world, in all media now in existence or hereafter developed.

I understand that this release does not restrict whatever rights MINIART FAMILY HOME DAY CARE, LLC has by law.

PRINT CHILD'S FULL NAME:_____

ADDRESS:_____

_____

SIGNATURE:_____

[if the subject is less than 18, this Release must be signed by a parent or legal guardian.]

I, the undersigned, being the parent or legal guardian of the person whose name appears above, do hereby consent to release and uses above.

PRINT PARENT/GUARDIAN FULL NAME:_____

ADDRESS:_____

_____

SIGNATURE:_____

PHOTOGRAPHER: CURRENTLY EMPLOYED MINIART FAMILY HOME DAYCARE, LLC TEACHERS.

ALL ABOUT YOUR CHILD

CHILDS FULL NAME:

EATING HABITS

DOES YOUR CHILD HAVE A SPECIAL DIET?

- ☐ YES
- ☐ NO

IF YES, PLEASE EXPLAIN.

LIST FOODS THAT SHOULD NOT BE SERVED TO YOUR CHILD:

FAVORITE FOODS

DOES YOUR CHILD EAT INDEPENDENTLY?

- ☐ YES
- ☐ NO

FOR INFANTS, WHAT BRAND OF FORMULA DO YOU USE?

DOES YOUR CHILD REQUIERE:

- ☐ SIPPY CUP
- ☐ HIGH CHAIR
- ☐ BOOSTER SEAT

SLEEPING HABITS

DOES YOUR CHILD HAVE A REGULAR BEDTIME SCHEDULE?

- ☐ YES
- ☐ NO

WHAT TIME DOES YOUR CHILD USUALLY WAKE UP?

WHAT TIME DOES YOUR CHILD GO TO BED?

DOES YOUR CHILD TAKE NAPS?

- ☐ YES
- ☐ NO

IF YES, HOW LONG ARE THE NAPS?

DOES YOUR CHILD HAVE ANY PROBLEMS GETTING TO SLEEP OR STAYING ASLEEP?

- ☐ YES
- ☐ NO

IF YES, PLEASE EXPLAIN.

HEALTH CONCERNS

DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONCERNS?

- ☐ YES
- ☐ NO

IF YES, PLEASE DESCRIBE.

DOES YOUR CHILD TAKE ANY MEDICATION ON A REGULAR BASIS?

☐ YES
☐ NO

IF YES, PLEASE LIST THE MEDICATIONS, DOSAGE AND HOW OFTEN TAKEN.

ARE THERE ANY HEARING OR VISION PROBLEMS?

☐ YES
☐ NO

IF YES, PLEAE DESCRIBE.

DOES YOUR CHILD HAVE ANY ALLERGIES?

☐ YES
☐ NO

IF YES, PLEASE LIST THE ALLERGY AND HOW IT IS DEALT WITH

LIST ANY COMMUNICABLE DISEASES YOUR CHILD HAS HAD:

DOES YOUR CHILD SUFFER FROM ANY OF THE FOLLOWING ON A REGULAR BASIS (check all that apply)?

☐ NOSEBLEEDS
☐ HEADACHES

- ☐ SORE THROAT
- ☐ STOMACHACHES
- ☐ RUNNY NOSE
- ☐ SEASONAL ALLERGIES
- ☐ OTHER_____

BEHAVIOR

HOW DO YOU "REWARD" OR "DISCIPLINE" YOUR CHILD?

ANYTHING ELSE ABOUT YOUR CHILD YOU FEEL WE SHOULD KNOW?

AUTHORIZATION AND WAIVER TO TRANSPORT CHILD

Child's Full Name: _____ DOB: _____

My child requires a booster seat: ☐ Yes ☐ No (All children under 8 years of age are required to be in a booster seat)

I authorize MiniART Family Home Day Care, LLC to transport my minor child in a company Bus or Van, driven by an individual authorized by MiniART Family Home Day Care, LLC. I understand my child is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the driver and/or staff or volunteer. I understand participation in the identified event is not a requirement for participation in the program.

I have read, understand, and discussed with my child:

1. My child will travel in a motor vehicle driven by an adult and my child is to wear their safety belt during travel;
2. My child is expected to listen to supervising staff/driver, respect staff and other children, the vehicles they ride in, and the people they travel with during the trip;
3. Riding in a motor vehicle may result in personal injuries or death from wrecks, collisions or acts by riders, other drivers, or objects; and,
4. My child is to remain in their seat and not be disruptive to the driver of the vehicle.

Initial Each Statement

_____ I recognize participation in this activity, as with any activity involving motor vehicle transportation, my child may risk personal injury or permanent loss. I hereby attest and verify I have been advised of the potential risks, and I have full knowledge of the risks involved in this activity, and I assume any expenses incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

_____ As a condition for the transportation received, I, for myself, my child, my executors and assigns, further agree to release and forever discharge MiniART Family Home Day Care, LLC , and their agents, officers, employees and volunteers from any claim that I might have myself or that I could bring on my child's behalf with regard to any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation.

_____ I have read this entire waiver and authorization form, I fully understand its terms and conditions, and I agree to be legally bound by its terms.

_____	_____	_____
Parent/Guardian Name	Signature	Date

AUTORIZATION FOR EMERGENCY TREATMENT

Permission for the Licensed Child Care Provider to take the steps that may be necessary for medical care of an emergency is hereby given. I understand that the order of actions taken will follow the outline below unless there is a need for immediate action, but will not be limited to these actions:

1. Parent or guardian will be called.
2. Contact person(s) that parents have listed on the registration form will be called.
3. If non of these efforts are successful:
    a. An ambulance will be called.
    b. The child will be taken to the nearest emergency room.

In order for the family home day care to assume responsibility for my child, I understand that I must sign the child in at arrival time and out at departure time.

_____	_____	_____
Parent/Guardian Name	Signature	Date

EMERGENCY/HEALTH FORM

CHILD'S FULL NAME:	
DOB:	AGE:
ADDRESS:	
HOME PHONE:	
MOTHER'S NAME:	
WORK PHONE:	CELL PHONE:
FATHER'S NAME:	
WORK PHONE:	CELL PHONE:
EMERGENCY CONTACTS	
NAME:	PHONE:
NAME:	PHONE
CHILD'S DOCTOR:	PHONE:
	ADDRESS:
ARE IMMUNIZATIONS UP TO DATE?	YES NO
CHILD'S DENTIST:	PHONE:
	ADDRESS:
LIST ANY SPECIAL PROBLEMS: (surgeries, allergies, communicable diseases, etc.	

_____ _____ _____

Parent/Guardian Name Signature Date

RECEIPT OF HANDBOOK

I, _____, have received the MiniART Family Home Day Care, LLC Parent Handbook and Handouts.

HANDBOOK	Initials
Waiver	
Religion	
Payments and other cost	
Enrollments, Confidentiality, Supplies	
Holidays, Vacations, Alternate care	
Under the influence & Termination	
Nutrition, Naps & SIDS	
Daily Schedule & Activities	
Illness Guidelines	
Medications	
Discipline & Positive Guidance Techniques	
Arrivals and Departures	

HANDOUTS	Initials
Rate Sheet	
Emergency Plans	
Daily Schedule	
Closed Holiday & Vacation Schedule	
Child Care Application for Enrollment Form	
Child Care Food Program Forms X3	
Enrollment Contract	
Immunization Forms	
State of Florida School entry Health Exam Form	
Emergency/Health Form	
Influenza Virus Form	
Authorization for Emergency Form	
Authorization for Prescription and Nonprescription Medication	
Permission for Food-related Activities & Special occasion food consumption	
All about your Child Form	
Transportation/Field Trip Authorization Form	
Media Release Form	

This is to verify that I have read MiniART Family Home Day Care, LLC Parent Handbook and Handouts. I agree to comply with the policies outlined in the parent handbook.

_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date

State of Florida
Department of Children and Families

CHILD CARE APPLICATION FOR ENROLLMENT

Student Information: Date of Birth: _____ Sex: ____ Date of Enrollment: _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

Primary Hours of Care: From: _____ To: _____

Days of the Week in Care: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Press space bar once to check a box; press space bar once to uncheck a checked box.

Family Information: Child's Lives With: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____ Cell: _____ Work Phone: _____ Cell: _____
(including area code) (including area code)

Custody: ☐ Mother ☐ Father ☐ Both ☐ Other (specify): _____

Medical Information: I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address: _____

Phone Number: _____

Doctor: _____ Address: _____

Phone Number: _____

Dentist: _____ Address: _____

Phone Number: _____

Hospital Preference: _____

Please list allergies, special medical or dietary needs, or other areas of concern:

Emergency Care Plan Instructions (if applicable):

Emergency Contacts: Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

(including area code)

Name	Address	Work Phone	Home Phone
Name	Address	Work Phone	Home Phone
Name	Address	Work Phone	Home Phone
Name	Address	Work Phone	Home Phone

Helpful Information About Child:

- Sections 7.1 and 7.2 of the Child Care Facility Handbook require a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.
- Section 7.3 of the Child Care Facility Handbook requires that parents receive a copy of the Child Care Facility Brochure entitled "Know Your Child Care Facility" (CF/PI 175-24) [also available on-line at https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=860], **or**
- Section 8.3 of the Family Day Care Home/ Large Family Child Care Home Handbook requires that parent(s) receive a copy of the family day care home brochure entitled "Selecting A Family Day Care Home Provider" (CF/PI 175-28) [also available on-line at https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=841].
- Section 2.8 of the Child Care Facility Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the child care facility, **or**
- Section 2.3 of the Family Day Care Home/ Large Family Child Care Home Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the family day care provider.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

Signature of Parent/Guardian _____ Date _____

Florida Department of Health
Child Care Food Program

CHILD CARE APPLICATION FOR ENROLLMENT

Student Information: Date of Birth: _____ Sex: ___ Date of Enrollment _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

Primary Hours of Care: From _____ To _____

Days of the Week in Care: M ☐ T ☐ W ☐ Th ☐ F ☐ Sa Su

Meals Typically Served While in Care: Br ☐ AM Snack Lunch ☐ PM Snack ☐ Supper Eve Snack

Family Information:

Parent 1 Name: _____ Parent 2 Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____/Cell: _____ Work Phone: _____/Cell: _____

Child Lives With: Parent 1 ☐ Parent 2 ☐ Both Parents ☐ Other ☐

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address: _____ Phone: _____

Doctor: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Hospital Preference: _____

Please list allergies, special medical or dietary needs, or other areas of concern: _____

_____

_____

Emergency Care Plan Instructions (if applicable): _____

_____

Emergency Contacts:

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

Name	Address	Work#	Home#
Name	Address	Work#	Home#
Name	Address	Work#	Home#
Name	Address	Work#	Home#

Helpful Information About Child:

_____

_____

_____

_____

_____

- Sections 7.1 and 7.2 of the Child Care Facility Handbook require a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.
- Section 7.3 of the Child Care Facility Handbook requires that parents receive a copy of the Child Care Facility Brochure, "Know Your Child Care Facility" (CF/PI 175-24), **or**

  Section 8.3 of the Family Day Care Home/Large Family Child Care Home Handbook requires that parent(s) receive a copy of the family day care home brochure, "Selecting A Family Day Care Home Provider" (CF/PI 175-28.
- Section 2.8 of the Child Care Facility Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the child care facility, **or**

  Section 2.3 of the Family Day Care Home/Large Family Child Care Home Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the family day care provider.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

1st year:

_____ _____

Signature of Parent/Guardian Date

Subsequent years:

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

Child Care Food Program

Infant Feeding Form

Child care facility: Please fill in facility name and formulas offered before distributing to parents.	
Child Care Facility Name:	
*Formulas offered at this facility: Milk-based:	
Soy-based:	

This child care facility participates in the Child Care Food Program (CCFP) and is required to offer infant formula and food to your baby. The CCFP provides reimbursement for healthy meals provided and served to your baby while in our care. Our child care staff have been trained in infant feeding practices and offer age appropriate foods for your baby.

We welcome breastfed babies and support and encourage moms to continue breastfeeding when returning to work or school. For formula fed infants, we offer the iron-fortified infant formulas listed above to babies in our care.

To qualify for reimbursement, infant meals and snacks must include, at a minimum, the following food components at appropriate age and developmental stages:

- Breastmilk or iron-fortified infant formula (or a combination of both)
- Iron-fortified infant cereal
- A variety of texture-appropriate vegetables and fruits such as sweet potatoes, bananas, and peas.
- A variety of texture-appropriate meat and meat alternates such as chicken, yogurt, and cheese.
- Bread, crackers, Florida WIC-approved ready-to-eat cold cereals

Please be aware this child care facility:

- Will offer all food components to each infant that is developmentally ready to accept them. Parents do not have to bring in any foods for their children.
- Can feed solid foods to infants in a bottle only when a medical statement is provided.
- May request parents to supply clean, sanitized and labeled bottles on a daily basis.
- Requires the parent to label bottles of breastmilk or formula and containers of food that they provide with baby's name, date, and time of bottle or food preparation.

Parents please complete the following:

Baby's full name: _____ Date of Birth: _____

Please check ✓ this box ☐ if your baby is breastfed. Please check if you plan to do one or both:

Provide pumped breastmilk in a bottle ☐ Visit facility to nurse ☐

I understand that this child care facility will supply the above iron-fortified formulas for formula-fed infants up to 12 months of age and infant cereal and baby food for infants 6 months and older, according to the CCFP requirements.

I prefer to supply my own formula (write in name of *formula): _____

This facility has not requested or required me to provide infant formula or food.

Parent Signature: _____ Date: _____

Printed Name of Parent: _____

*Please note. Early Head Start facilities provide the brand of formula you currently give your infant as well as all age-appropriate food

Child Care Food Program
Medical Statement for Children with Disabilities

Child's Name: _____ Date: _____

Name and Address of Child Care Center: _____

_____

Dear Parent/Guardian and Recognized Medical Authority:

Child care providers must make reasonable modifications to meals to accommodate disabilities which restrict a child's diet. A disability means any person who has a physical or mental impairment which substantially limits one or more "major life activities." "Major life activities" include eating, digestion, and feeding skills. A physical or mental impairment does not need to be life threatening to constitute a disability. Examples of a disability may include diabetes, food allergy/intolerance, developmental delay, or autism.

When substitutions are made and the meal pattern is not met, a medical statement is required and must be signed by a physician, physician's assistant (PA), or nurse practitioner (ARNP). Please return this completed form to the child care center. If you have any questions, please contact me at _____. Sincerely, _____

Child Care Center Phone Child Care Center Director

A recognized medical authority must complete the following information.

State and describe the disability.

_____

How does the disability restrict the diet?

_____

List any food(s) to be omitted from the child's diet.

_____

List any food(s) to be substituted.

_____

Describe any textural modification or adaptive equipment required.

_____

_____ _____

Signature of Physician or Recognized Medical Authority Date
(For a disability – a physician, PA, or ARNP must sign)

_____ _____

Printed Name Phone Number

Parent must complete the following information.

This facility has not requested or required me to provide special food for my child.

Parent Signature: _____ Date: _____

Printed Name of Parent: _____

Child Care Food Program
Sample Medical Statement for Meal Modifications

Child care facility staff must complete the following information:

Child's Name: _____ Date: _____

Name of Child Care Facility: _____

Facility Address: _____ Phone Number: _____

Child Care Facility Director Name: _____

Dear Parent/Guardian and Recognized Medical Authority:

Reasonable modifications *must* be made for children with disabilities that restrict their diet. A person with a disability means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such a disability, or is regarded as having such a disability. Major life activities are broadly defined and include, but are not limited to, eating, digestion, and feeding skills. A physical or mental impairment does not need to be life threatening to constitute a disability. Examples of a disability may include diabetes, food allergy or intolerance, developmental delay, or autism.

When substitutions are made and the meal pattern is not met, a medical statement is required and must be signed by a physician, physician's assistant (PA), or nurse practitioner (ARNP).

Please return this completed form to the child care center. If you have any questions, you may contact the facility.

A recognized medical authority must complete the following information:

Describe the physical or mental impairment that restricts the child's diet:

_____

Foods to be Omitted:	Foods to be Substituted:
_____	_____
_____	_____
_____	_____

Describe any textural modification, adaptive equipment, or other modifications required:

_____

_____ Signature of Physician or Recognized Medical Authority
(For a disability – a Physician, PA, or ARNP must sign)

_____ Date

_____ Printed Name

_____ Phone Number

A parent or guardian must complete the following information:

☐ Check box if request is regarding a religious or dietary *preference only* (medical authority signature not required)

I certify that this facility has not requested or required me to provide special food(s) for my child. I understand that my child care facility *is required* to provide special food(s) for children with disabilities. Requests for modifications due solely to preference are encouraged but not required.

Parent Signature: _____ Date: _____

Printed Name of Parent: _____ Parent Phone Number: _____

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

⌦ _____ _____
Signature of Parent/Guardian **Date**

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____ _____ _____
(Exam must be within one year of enrollment) Month Day Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐ Failed ☐ Referred ☐
Vision - With Glasses	Right 20/_____	Left 20/_____		Hearing – Left	Passed ☐ Failed ☐ Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
⌧	___/___/___	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

A change in daily routine, lack of sleep, stress, fatigue, cell phone use, and simple distractions are some things parents experience and can be contributing factors as to why children have been left unknowingly in vehicles...

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

MYFLFAMILIES.COM

Developed by:

The Office of Child Care Regulation

www.myflfamilies.com/childcare
CF/PI 175-12, May 2018

When life happens…Don't be a

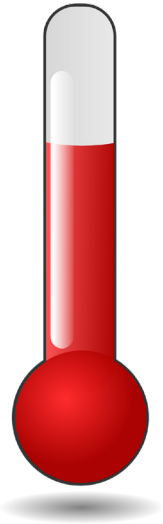
DISTRACTED ADULT

FACTS ABOUT HEATSTROKE:

It only takes a car **10 minutes to heat up 20** degrees and become deadly.

Even with a **window cracked,** the temperature inside a vehicle can cause heatstroke.

The body temperature of a child increases **3 to 5 times faster** than an adult's body.



⚠ PREVENTION TIPS:

- Never leave your child alone in a car and call 911 if you see any child locked in a car!
- Make a habit of checking the front and back seat of the car before you walk away.
- Be especially mindful during hectic or busy times, schedule or route changes, and periods of emotional stress or chaos.
- Create reminders by putting something in the back seat that you will need at work, school or home such as a briefcase, purse, cell phone or your left shoe.
- Keep a stuffed animal in the baby's car seat and place it on the front seat as a reminder when the baby is in the back seat.
- Set a calendar reminder on your electronic device to make sure you dropped your child off at child care.
- Make it a routine to always notify your child's child care provider in advance if your child is going to be late or absent; ask them to contact you if your child hasn't arrived as scheduled.

During the 2018 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes to provide parents, during the months of April and September each year, with information regarding the potential for distracted adults to fail to drop off a child at the facility/home and instead leave them in the adult's vehicle upon arrival at the adult's destination.

My signature below verifies receipt of the Distracted Adult brochure

Parent/Guardian:

_____

Child's Name:

_____

Date:

_____

Please complete and return this portion of the brochure to your child care provider, to maintain the receipt in their records.

During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

My signature below verifies receipt of the brochure on *Influenza Virus, The Flu, A Guide to Parents:*

Name:_____

Child's Name: _____

Date Received:_____

Signature:_____

Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.

What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse

How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

For additional helpful information about the dangers of the flu and how to protect your child, visit: http://www.cdc.gov/flu/ **or** http://www.immunizeflorida.org/

What is the influenza (flu) virus?

Influenza ("the flu") is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

How can I tell if my child has a cold, or the flu?

Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

Florida Department of Children & Families

For additional information, please visit www.myflorida.com/childcare or contact your local licensing office below:

CF/PI 175-70, June 2009

This brochure was created by the Department of Children and Families in consultation with the Department of Health.

"The Flu" A Guide for Parents

INFLUENZA VIRUS

Child Care Facility

Authorization For Prescription and Non-Prescription Medication

No medication shall be given by child care personnel without the signed permission of the parent or legal guardian. All medication must be in the original container with the child's name, name of the physician, medication name, and medication directions written on the label.

Non prescription medication brought in by the parent or legal guardian can only be dispensed if there is written authorization from the parent or legal guardian to do so.

Medication which has expired or is no longer being administered shall be returned to the parent or legal guardian.

Child's Name: _____ Age: _____

1. Medication Name: _____
   Amount to be Given: _____
   Time to be Given: _____

2. Medication Name: _____
   Amount to be Given: _____
   Time to be Given: _____

Record of Medications Given:

1. Medication Name: _____

Date & Time	Amount	Employee

2. Medication Name: _____

Date & Time	Amount	Employee

This authorization form must be maintained and is only valid for the duration of prescription.

I hereby give permission to dispense the medication(s) listed above in accordance with the written directions on the prescription label or printed manufacturer's label.

_____ _____

Parent/Guardian Signature Date

(Retain in child's file for a minimum of four months)

Permission for *Food-related Activities & Special Occasion* food consumption

Pursuant to 65C-22.005(1)(c)2., F.A.C., licensed child care facilities must obtain written permission from parents/guardians regarding a child's participation in food related activities. These activities include such things as: classroom cooking projects, gardening, school wide celebrations, and birthdays.

I _____ give/decline permission for my child_____
(Parent or Guardian) ***(circle one)*** ***(Child's Name)***

to participate in food related activities and special occasions wherein food is consumed.

Please provide the following information:

____My child DOES NOT have a food allergy or dietary restriction. He or she may participate in activities.

____My child DOES NOT have a food allergy or dietary restriction. He or she <u>may not</u> participate in activities.

____My child DOES have a food allergy or dietary restriction. He or she may participate in activities, but may not eat or handle the following items (please list below):

_____
_____
_____
_____

____My child DOES have a food allergy or dietary restriction. He or she <u>may not</u> participate in activities

I understand that it is my responsibility to update this form in the event that my decision for permission changes. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____
(Parent or Guardian) **(Date)**

SAMPLE