

***EXTENDED CARE REGISTRATION
2018-19***

Parents _____ **Phone** _____

Child(ren) _____ **Grade** _____

_____ **Grade** _____

_____ **Grade** _____

My children will be attending care:

_____ **Before School most days** _____ **Before School occasionally**

_____ **After School most days** _____ **After School occasionally**

_____ I have received the Parent Handbook for North American Martyrs Extended Care Program. I understand and agree to follow the guidelines of the program.

Parent Signature

Date



Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name: _____ Birthdate(s): _____

Enrollment Date: _____ Updates: _____ Date Care Ceased: _____

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: _____ Employer: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

MOTHER (or Guardian):

Name: _____ Employer: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____

Caregiver

to contact Doctor _____

Name of Physician

Phone _____

and, if necessary, take my child(ren) to the

Address _____

City _____

following doctor(s), clinics, or hospital _____

Signature of Parent/Guardian _____

Date _____

MEDICATION COMPETENCY STATEMENT

I, _____ have determined

Parent /Guardian Name

that _____ is/are competent to give or apply medication to my child(ren).

Provider/Director/Staff Name(s)

Signature of Parent/Guardian _____ Date _____

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____

Medication, if any: _____

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____

Special Concerns: (Glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian _____

Date _____

CACFP Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

I Accept the formula
 I Decline the formula
 I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
 Parent will provide breast milk
 Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

| Last Name | First Name | Date of Birth | Date Enrolled |
|---|--|---|---|
| Usual Days in Care | | Usual Hours in Care | |
| <input type="checkbox"/> Monday | 3:15 pm to 5:45 pm | Usual Meals Received While in Care <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input checked="" type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack | Optional: Ethnic Identity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Racial Identity <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White |
| <input type="checkbox"/> Tuesday | 3:15 pm to 5:45 pm | | |
| <input type="checkbox"/> Wednesday | 3:15 pm to 5:45 pm | | |
| <input type="checkbox"/> Thursday | 3:15 pm to 5:45 pm | | |
| <input type="checkbox"/> Friday | 3:15 pm to 5:45 pm | | |
| <input type="checkbox"/> Saturday | to | | |
| <input type="checkbox"/> Sunday | to | | |
| <input type="checkbox"/> Non-school days/holidays | to | | |
| <input type="checkbox"/> Check if Head Start eligible | <input type="checkbox"/> Check if infant under one year of age | | |

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| <input type="checkbox"/> Saturday | to | | |
| <input type="checkbox"/> Sunday | to | | |
| <input type="checkbox"/> Non-school days/holidays | to | | |
| <input type="checkbox"/> Check if Head Start eligible | <input type="checkbox"/> Check if infant under one year of age | | |

Annual Update

Parent may sign & date if the enrollment information is correct.

| | |
|-----------|-------|
| Signature | Date |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Signature of Parent or Legal Guardian _____

Printed Name _____

Street Address _____

City, State, Zip _____

Telephone (include area code) _____

Date signed: ____/____/____
 Month Day Year

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Licensed Child Care

You have chosen to use a licensed Child Care provider for the care of your child or children. Nebraska Law requires anyone providing care to four or more children from different families, for compensation, to be licensed. The Types of Licensed Child Care in Nebraska are:



- Family Child Care Home I
- Family Child Care Home II
- Preschool
- Child Care Center
- School-Age Only Center



Responsibilities of Child Care Licensing

The roles and responsibilities of DHHS Child Care Licensing staff are to ensure that programs are providing proper care for and treatment of the children they serve, and that the care and treatment are consistent with the child's physical well-being, safety, and protection.

Licensed Child Care programs are encouraged to involve you. We urge you to let your Child Care providers and/or staff know of any concerns. There may be situations where you believe that the program is not responding to your concerns or may not be meeting state licensing standards. This brochure, which Child Care providers are required to share with you, provides information that might be helpful in those situations.

Please complete the receipt section and return it to your Child Care provider. This will be kept with your child's records.

Responsibilities of Licensed Child Care Provider

Comply with child care regulations for their license type at all times.

Obtain and maintain accurate records for children they have in care, such as Enrollment Forms, Parent Information Brochure Receipts, Immunization Records and Medication Administration records.

Keep accurate and up-to-date records for their license on themselves and staff members. Report changes to Child Care Licensing and complete required paperwork to reflect changes.

Allow access to their licensed facility when children are in care at all times to parents, Child Care Licensing representatives and the Fire Marshal.

Develop policies and procedures for their programs.

Communicate with families their needs and concerns for the children in care.

Contact Child Care Licensing with any questions or concerns they may have.

COMPLETE THE OTHER SIDE
AND RETURN TO
YOUR CHILD CARE PROVIDER

A large, stylized illustration of a child's play structure, similar to the one in the top right, but rendered in a more artistic, shaded style. It features a central tower and side supports, with a textured, almost fabric-like appearance.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

Parent Information Brochure For Licensed Child Care



Nebraska Child Care Licensing Website:
<http://dhhs.ne.gov/publichealth/pages/crlChildCareLicensingIndex.aspx>

Expectations of Child Care Consumers

Read thoroughly all the information your provider gives you.

Complete your Child's Record Forms and return to your provider before your child begins care. Review and update these records as needed.

Supply your provider with your child's immunization records and keep them updated as needed.

Sign and date the receipt of this Parent Information Brochure for Licensed Child Care and return it to your provider before your child begins care.

Talk to your Child Care provider regularly to address needs and concerns for your children in care and as a parent.

Contact Child Care Licensing with any questions or concerns you may have.

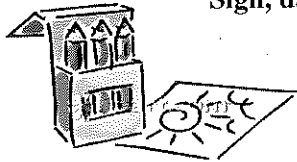
Email: DHHS.ChildCareLicensing@nebraska.gov

Phone: 800-600-1289 OR 402-471-6564

Mail: Nebraska Child Care Licensing
Department of Health and Human Services
PO Box 94986
Lincoln, NE 68509-4986

Sign, date and return to your Child Care provider before your child(ren) begin care.

Your Child Care Provider must retain this receipt for onsite review.



Child Care Program Name: _____

Enrolled Child(ren)' Names: _____

Parent/Guardian Names: _____

Parent/Guardian Signature: _____