Parent/Guardian Information- To be billed by WSU: WSU ID Number:_____

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ WSU Email:_____

WSU Department or Work Place:_____ Work Phone:_____

Work Hours:_____ Department Reception Phone Number:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty ◯ Staff ◯ Other:_____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Parent/Guardian Information : ☐ None WSU ID Number:_____

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Email:_____

WSU Department or Work Place:_____ Work Phone:_____

Affiliation with WSU: ◯ Undergraduate ◯ Graduate Student ◯ Faculty ◯ Staff ◯ None

Child Information

First Name:_____ Last Name:_____

Name child prefers to be called:_____ Gender: ◯ Male ◯ Female

Date of Birth (mm/dd/yyyy):_____/_____/_____ Primary Language used at home:_____

Lives With:_____ Enrollment Start Date (mm/dd/yyyy):_____

Enrollment Schedule:

☐ Full time: (7:30am-5:30pm) ☐ Part-Time: 7:30-12:30 or 12:30-5:30 ☐ Evening Care 5:30-9:30 M-Th

☐ School Age: (Before/After School Care and scheduled school closures)

Emergency Contact /Other than Parents/Guardians

Emergency Contact 1: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Emergency Contact 2: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Emergency Contact 3: First Name: _____ Last Name: _____

Cell phone: _____ Home Phone: _____ Gender: ◯ Male ◯ Female

Address: _____ Relationship to Child/Family: _____

Authorized to pick up child from WSUCC? ◯ Yes ◯ No

Is this contact person currently affiliated with WSU? ☐ No ☐ Yes, please specify _____

Primary language(s) spoken: _____

Guests to WSUCC: All guests (emergency contacts) will be required to identify themselves at the front desk and present a valid form of ID. If your guest will become a regular person who picks up your child, they can register for a computer code in our system. It may be requested of your guest to take a photo for our computer system for security purposes. All authorization for a person other than the parent/guardian checking children out of the Children's Center MUST be in writing.
Parents are responsible for updating all emergency contact information whenever it changes. WSUCC reserves the right to make contact with any and/or all of the emergency names listed above.
If there is a custody or other legal agreement/document that limits a parent/guardian's contact with a child or that prohibits a parent/guardian from picking up a child, WSUCC MUST have a copy of the legal document on file.

Parent/Guardian Signature:	**Date**
Printed Name:	

WSUCC EVENING CARE SERVICE AGREEMENT 2017-2018

Family Information: Parent to be billed MUST be a WSU student, staff, faculty member, or WSU affiliation.

Parent to be billed by WSU: WSU ID Number:_____ Relationship to Child:_____

First Name:_____ Last Name:_____

WSU Email: _____ Phone Number:_____

Affiliation with WSU: ☐ Undergraduate ☐ Graduate Student ☐ Faculty/Staff ☐ Other, Please Specify:_____

Parent 2: WSU ID Number:_____ Relationship to Child:_____

First Name:_____ Last Name:_____

WSU Email or other: _____ Phone Number:_____

Affiliation with WSU: ☐ Undergraduate ☐ Graduate Student ☐ Faculty/Staff ☐ None

Child's Name:	Date of Birth:
Child's Name:	Date of Birth:
Child's Name:	Date of Birth:
Child's Name:	Date of Birth:

Evening Care Availability:

- Evening Care is available during the academic school year, **excluding** finals weeks, university holidays and closures. Any other closures as determined by WSUCC.
- Space is available on a first-come, first-served basis.
- Registration must be completed online before **2pm on the day care is needed, there is no registration by phone or in person.** Registration can be done up to 2 weeks in advance online.

Evening Care Conditions of Service

- Completion of an enrollment packet prior to attending is required.
- Payment of the $50 registration fee before services can be provided.
- At the start of every fall semester a USDA Child and Adult Care Food Program form must be completed by each family.
- Every child must have a signed Certificate of Immunization Status prior to the start of care. Additionally immunizations must be kept up to date and records provided to WSUCC, **if a child becomes out of compliance they will be excluded from care.**
- If a child is also enrolled at WSUCC during our daytime hours (7:30am-5:30pm), **the child's total hours in care for the day must not exceed 10 hours.**

Additional Charges & Fees:

- Evening Care is available Monday-Thursday, 5:30-9:30pm. **Extended hours are not available.**
- If a child is registered for the evening and does not show, a no-show fee will be applied to the account for each child that does not attend. If you must cancel services please do so by 2pm on the same day. To cancel your registration log into your account and cancel the registration for each night you no longer need services, you may also call the center to cancel before 2pm on the same day.

Payments - *No payments can be accepted at the Children's Center*

- Payments may be made online at www.childrenscenter.wsu.edu using Visa or MasterCard (or debit card displaying Visa/MasterCard logo).
- To pay by check or cash, payment can be made at the Cashier's Office in the French Administration Building, Room 342.

Policies and Procedures

- The most current Family Handbook is available online at www.childrenscenter.wsu.edu
- WSUCC reserves the right to update policies and practices on an as-needed basis in order to comply with state laws/regulations, university policies, and to ensure quality care.
- Families will be notified of any changes to policies and/or procedures.

WSU Children's Center Inclement Weather/Emergency Closure Policy

- As a "nonessential" service at WSU, if the university suspends operations or closes due to weather or other emergencies, the Children's Center will close.

Illness Policy

- If a child is showing signs of illness at drop-off they will not be permitted to stay. Please make other arrangements for your child when they are ill.
- If your child becomes ill while at the center, we will contact you or your emergency contacts if you cannot be reached. Please come get your child immediately after we call you. **If your child is still at the center more than an hour after you've been contacted, a $15 per hour fee may be assessed.**

I have read and agree to the service conditions as outlined above. I agree to follow all the policies of the WSU Children's Center. I understand that it is my responsibility to update my contact information whenever there is a change. All changes to emergency contacts/approved persons that my pick up my child, MUST be in writing. If I have any concerns or questions about the Evening Care Program, I will address these with the Evening Care Supervisor or the Director.	
Parent/Guardian Signature	Date
Parent Name Printed:	

Health Care Packet

As a licensed child care program we are required to meet state licensing standards. By completing the following forms this ensures that WSUCC complies with licensing and helps our staff to provide excellent care for your child. If you have any questions about the forms, please let us know.

Health History (Required) - This form is required for all children enrolled at WSUCC. Please fill out all sections of the form. *In cases where a child is too young to have a dentist, write/mark "none at this time." If you are new to the area and have not established a primary care physician you may write in "none at this time", and update this information later.*

Certificate of Immunization Status (CIS) Form (Required)- This form is required for all children enrolled at WSUCC, it must be signed by a parent/guardian to be valid. Your Health Care Provider may be able to print this form for you from the Immunization Information System. This form must be updated with vaccinations that your child receives while in care, a print out from your Health Care Provider or a copy of the state vaccination record can be used to update the CIS Form.

If your child has an allergy or intolerance please complete the following forms:

Allergy & Intolerance IHP Packet: Please help us to comply and meet the health needs of your child by completing the Allergy/Intolerance Statement form. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually.

Allergy Medication Authorization Form: If your child requires medication during the day, please have your Health Care Provider fill out this form. Please make sure to check expiration dates on medications periodically and replace as necessary.

If your child has asthma please complete the following forms:

Asthma Individual Health Plan- Please help us to comply and meet the health needs of your child by completing the Asthma Individual Health Plan. In the event that your child experiences asthma symptoms we need to be informed on the actions to take to help relieve their symptoms. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually. . *In the event it is necessary for the use of provided medications for an asthma symptoms, a detailed medication record is kept on file and copies may be provided upon request.*

All fields on this form are required by licensing do not skip! If a field does not apply please mark as NA.

Child's Name (First & Last):	Date of Birth:

In case of an Emergency whom should be contacted first:

Relationship to Child	Name	Cell Phone Number	Work Phone Number	Home Number

Physician or Medical Facility

Name of Primary Care Office	Address	Phone Number
☐ None locally established		
Name of Primary Care Physician:		
Date of Last Physical:		

Dentist

Name of Dentist Office	Address	Phone Number
☐ None		

Authorization for Medical Care

I hereby give permission that my child may be given emergency treatment to include first aid and CPR by a qualified child care staff member of WSUCC. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health when I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or emergency vehicle for treatment.

Parent/Guardian Signature	Date

Please indicate if your child has any of the following Medical Conditions:

☐ No Known Allergies
☐ Food Allergies **(Please fill out a Food Allergy/Intolerance Statement**
☐ Non-Food Allergies **(Please fill out an Allergy Individual Health Plan)**
☐ Asthma **(Please fill out an Asthma Individual Health Plan)**

Any checked in this section will also require additional paperwork

☐ Diabetes ☐ Epilepsy/Seizure Disorder ☐ Cerebral Palsy/Motor Disorder
☐ Emotional/Behavior Disorder ☐ Gastrointestinal or feeding concerns (including special diets)
☐ Autism Spectrum Disorder ☐ Identified with a Cognitive Delay or Learning Disability
☐ Other conditions requiring special care

Please list any medication that your child is currently taking

Name of Medication	Dosage	Reason for Medication	Side Effects

Please note that any medication that will need to be administered during care by a staff member will need a Medication Authorization form completed.

Additional Information that may be helpful to child care provider

Signature of Parent/Guardian	**Date**
Please Print Full Name (First & Last)	

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 December 2016

Washington State Department of Health

VACCINES REQUIRED FOR CHILD CARE/PRESCHOOL ATTENDANCE

July 1, 2016 – June 30, 2017

	Hepatitis B	**DTaP** (Diphtheria, Tetanus, Pertussis)	**Hib** (*Haemophilus influenzae* type B)	**Polio**	**PCV** (Pneumococcal Conjugate)	**MMR** (Measles, Mumps, Rubella)	**Varicella** (Chickenpox)
By 3 Months (on or before last day of mo 2)	**2 doses** May get Dose 1 at birth and Dose 2 as early as 1 month of age	**1 dose**	**1 dose**	**1 dose**	**1 dose**	**Not given before 12 months of age**	**Not given before 12 months of age**
By 5 Months (on or before last day of mo 4)	**2 doses**	**2 doses**	**2 doses**	**2 doses** May get Dose 2 as early as 4 months of age	**2 doses**		
By 7 Months (on or before last day of mo 6)	**2 doses**	**3 doses** May get Dose 3 as early as 6 months of age	**3 doses**	**2 doses**	**3 doses**		
By 16 Months (on or before last day of mo 15)	**2 doses**	**3 doses**	**4 doses**	**2 doses**	**4 doses***	**1 dose** May get Dose 1 as early as 12 months of age	**1 dose** May get Dose 1 as early as 12 months of age **OR Healthcare provider verified disease**
By 19 Months (on or before last day of mo 18)	**3 doses**	**4 doses** May get Dose 4 as early as 12 months as long as 6 months separate Dose 3 and Dose 4	**4 doses**	**3 doses**	**4 doses***	**1 dose**	**1 dose OR Healthcare provider verified disease**
By 7 Years (on or before last day of year 6) **or by Kindergarten Entry**	**3 doses**	**5 doses**	**Not given after 5 years of age unless child has medical condition**	**4 doses**	**Not given after 5 years of age unless child has medical condition**	**2 doses**	**2 doses OR Healthcare provider verified disease**

***Some children may get 5 total doses. A single supplemental dose of PCV13 is recommended, but not required, for all children aged 14–59 months who got 4 doses of PCV7.**

- School-aged children (K-12) in before and after-school programs must meet the immunization requirements for their grade in school.
- Find information on other vaccines recommended, but not required, for child care/preschool attendance: www.immunize.org/cdc/schedules/
- Review the Individual Vaccine Requirements Summary for more detailed information: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx

Minimum Age & Interval for Valid Vaccine Doses

Vaccine	Dose #	Minimum Age	Minimum Interval Between Doses	Notes
Hepatitis B **(HepB)**	Dose 1	Birth	4 weeks between Dose 1 & 2	▪ The final dose in the series should be given at least 24 weeks of age.
	Dose 2	4 weeks	8 weeks between Dose 2 & 3	
	Dose 3	24 weeks	16 weeks between Dose 1 & 3	
Diphtheria, Tetanus, and Pertussis **(DTaP/DT)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ Typical vaccine schedule: 2, 4, 6, and 15-18 months of age. ▪ Recommended: 6 months between Dose 3 and Dose 4, but at least 4 months minimum interval acceptable.
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	12 months	6 months between Dose 4 & 5	
	Dose 5	4 years	--	
Haemophilus influenzae type B **(Hib)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ If all 3 doses of PedvaxHIB given, only need 3 doses total. ▪ Only one dose required if the dose given on or after 15 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
	Dose 4	12 months	--	
Pneumococcal Conjugate **(PCV7 or PCV13)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ A single supplemental dose of PCV13 recommended for all children 14–59 months of age who got 4 doses of PCV7. ▪ Only one dose required if the dose given on or after 24 months of age. Review the Individual Vaccine Requirements Summary for minimum doses required: www.doh.wa.gov/Immunization/schoolandchildcare/VaccineRequirements.aspx
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	8 weeks between Dose 3 & 4	
	Dose 4	12 months	--	
Polio **(IPV or OPV)**	Dose 1	6 weeks	4 weeks between Dose 1 & 2	▪ Three doses acceptable if child got Dose 3 on or after the 4th birthday.
	Dose 2	10 weeks	4 weeks between Dose 2 & 3	
	Dose 3	14 weeks	6 months between Dose 3 & 4	
	Dose 4	4 years	--	
Measles, Mumps, and Rubella **(MMR or MMRV)**	Dose 1	12 months	4 weeks between Dose 1 & 2	▪ MMRV (MMR + varicella) may be used in place of separate MMR and varicella vaccines. ▪ Must get the same day as VAR **OR** at least 28 days apart. ▪ 4-day grace **DOES** apply between doses of the same live vaccine such as MMR/MMR or MMRV/MMRV. The 4 day grace period **DOES NOT** apply between Dose 1 and Dose 2 of different live vaccines, such as between MMR and Varicella or between MMR and live flu vaccine.
	Dose 2	13 months	--	
Varicella (chickenpox) **(VAR)**	Dose 1	12 months	3 months between Dose 1 & 2 (12 months through 12 years) 4 weeks between Dose 1 & 2 (13 years and older)	▪ Recommended: 3 months between varicella doses, but at least 28 days minimum interval acceptable. Minimum age of 13 months acceptable. ▪ Must get the same day as MMR **OR** at least 28 days apart. ▪ 4-day grace **DOES** apply between doses of the same live vaccine; **DOES NOT** apply between doses of different live vaccines.
	Dose 2	15 months	--	

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DOH 348-053 December 2015

Child's Name:	Date of Birth:

Food Allergies, Intolerances, Restrictions, Preferences

☐ No Known Allergies. No religious/cultural restriction. No Personal Preferences.

☐ My child has a dietary restriction for medical reasons (such as a food allergy or other condition). If your child has dietary restriction **due to medical reasons, you MUST have your physician or health care provider complete a Food Allergy and Intolerance Packet** as required by the State of Washington, Department of Early Learning licensing regulations. This form provides WSUCC with specific information and instructions related to your child's food intake restrictions.

☐ My child has food intolerance. If you know or suspect that your child has food intolerance **(not an allergy)**, we require that your health care provider complete the Food Allergy and Intolerance Packet so that we have specific information and instructions related to your child's food intake restrictions.

☐ My child has a food restriction based on a religious/cultural value. Please eliminate the following food(s) from my child's diet:

☐ Beef ☐ Chicken ☐ Fish
☐ Pork ☐ Egg
☐ Other, please specify:

☐ My child is a Vegetarian. Food Service will prepare Vegetarian meals/snacks per their food preparation policy. Please indicate type of vegetarian:

☐ **Lacto-Vegetarians:** Who eat plant foods plus dairy products
☐ **Lacto-ovo Vegetarians:** Who consume both dairy products and eggs
☐ **Vegans:** Who avoid all animal products- no dairy, and eggs and eat only vegetables, fruits, and grains
Semi-Vegetarians: A semi-vegetarian could be a person who usually eats vegetarian but occasionally eats meat, for instance, or it could be someone who doesn't eat red meat but eats other meats.

Comments:

Additional Comments Related to Your Child's Food Needs:

Parent/Guardian Signature:	Date:

Family Handbook/Emergency/Emergency Disaster Plan/Health Care Policy & Fire Preparedness Plan
☐ I am aware that the WSUCC Family Handbook, Emergency Disaster Plan, Health Care Policy and Fire Preparedness Plan are available in booklet form or online at www.childrenscenter.wsu.edu . I have read and agree to abide by all of the policies and procedures as outlined in these documents and/or as amended by Washington State University. These handbooks include pertinent information such as licensing regulations, behavior management approaches, USDA Child Care Food Program, inclusion practices, billing procedures, open door policy, emergency disaster information, pesticide application practices, enrollment options, shelter-in-place precautions/procedures, and more. I understand that I may review a copy of these documents and/or receive a copy upon request.
☐ I authorize the WSU Children's Center to assess my child using professional developmental assessment tools including observation, Teaching Strategies Gold, and/or other similar assessment processes. These assessments will be used for the purpose of planning comprehensive individual and group learning opportunities. The information compiled using developmental assessment processes will be shared with me during parent-teacher conversation/conferences.
☐ I grant permission for my child to participate in all of the activities of the WSU Children's Center, under the supervision of a staff member, including classroom experiences, outdoor play, stroller rides, rainy day indoor play, and other developmentally appropriate opportunities.
☐ My child has/have permission to participate in walking field trips, under the supervision of a staff member. Walking field trips may include a variety of on-campus sites such as the art museum, parent offices, athletic facilities/functions, or other appropriate locations. Off-campus walking field trips may include sites such as parks, the public library, downtown locations, or other interesting locations. If a vehicle will be used to transport my child, I will be given an authorization form that I must sign that allows permission for my child to participate in that specific field trip experience.
Photos of the children will be taken for use in the Procare system, classroom allergy chart, and classroom use such as documentation of participation in learning experiences, preparation of child portfolios, observational processes, developmental assessment strategies, and similar purposes. In addition, I grant permission for photographic images (photos or videos) of my child to be taken by Children's Center staff and used for the following purpose(s). I understand that I will not receive compensation for the use of my child's photographs nor will I have ownership rights to the photographs/videos. ☐ WSU Children's Center use (e.g. inclusion in classroom/center-based newsletters, classroom activity summary pages, celebrations of success, and more.) ☐ WSU use (e.g. marketing materials such as the Children's Center flier, Family Handbook, or informational web pages, early childhood professional purposes such as documentation of quality care initiatives).

Child(ren) Information	
Child's Name	Date of Birth

Parent/Guardian Signature	**Date**

We want to do our best to make your child feel welcome.

Child's name and nickname?:_____

What are your child's likes?:_____

What are your child's dislikes?:_____

Favorite Toy?:_____

Favorite Story?:_____

Pets- Name and type of animals?:_____

_____

Favorite family activities?:_____

What makes him/her happy ☺?:_____

What makes him/her sad ☹?:_____

What are some favorite food?_____

What foods does he/she dislike?:_____

How does he/she like to be put down for a nap?:_____

_____

Does he/she have siblings? What are their name(s) and age(s)?:_____

_____

What other family members and friends are important to your child?_____

_____

The following space is provided for your to tell us about things you feel we should know about your child:_____

_____

_____

Thank you for helping us get to know your child.

CHILDREN'S CENTER ILLNESS POLICY

Child(ren) Information	
Child's Name	Date of Birth

Illness: In order to keep our children healthy, ill children with fever, vomiting, diarrhea or a communicable disease will not be permitted to remain at the center while they are sick. Please make alternate arrangements for your child when he/she is ill. We follow physician's recommendations on the length of time a child or staff member should remain at home after an illness. A child must stay home 24 hours after beginning medication, except in cases of ear-infection or non-contagious condition.

WHEN A CHILD BECOMES ILL AT THE CENTER

We will telephone you or contact your listed emergency contacts if you cannot be reached. Please let us know where you'll be on your parent class or work schedule, please update your schedule when there are changes.

When possible we will take ill children to our sick room behind the main office. Please come and get your child immediately after we call you. If your child is still at the center more than an hour after you've been contacted, a $15 per hour fee may be assessed.

IMPORTANT: Please keep your child's file up to date with phone numbers, offices where you can be found, your child's doctor and person to call in case of emergency.

Refunds or credits are NOT granted if a child does not attend due to illness

Children are not permitted to remain at the center with any of the following conditions:

1) Vomiting: two or more episodes in 24 hours
2) Rash, lice or nits. Body rash, especially with fever or itching
3) Diarrhea: 3 or more watery stools in 24 hours ***(Diapered children: one occurrence where stool is uncontained).***
4) Eye infection. Thick mucus or pus draining form the eye.
5) Sore throat with fever or swollen glands.
6) Unusually tired, pale, lack of appetite, confused, cranky or ***unable to participate in activities.***
7) Fever. Temperature of 100 degrees (F) or more (taken under the arm).

Other exclusions are listed in the Family Handbook, along with the return to care instructions. If you have questions or concerns, please ask an Administrative Team Member.

Medication: Prescription medications are administered by staff only with written permission from parents and/or physician. Prescriptions must be the original container and the consent must include the following:

- Child's first and last name
- Name of medication to give
- Reason for giving medication
- Amount of medication to give
- How to give the medication (route)
- How often to give the medication
- Start and stop dates
- Expected side effects
- How to store the medication consistent with directions on the medication label
- Child MUST have had the medication prior to use at the Children's Center

Please refer to the Family Handbook for more information on the medication policy and illnesses/conditions that can exclude a child from attending.

Parent/Guardian Signature	Date

Please update this form whenever there is a change in your schedule									
Child's Name					Semester	Fall	Spring	Summer	Year
Parent/Guardian Name							Daytime Phone		
Please provide your location during each specified time frame									
Day of Week	8-9am	9-10am	10-11am	11am-Noon	Noon-1pm	1-2pm	2-3pm	3-4pm	4-5pm
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									

Please update this form whenever there is a change in your schedule									
Child's Name					Semester	Fall	Spring	Summer	Year
Parent/Guardian Name							Daytime Phone		
Please provide your location during each specified time frame									
Day of Week	8-9am	9-10am	10-11am	11am-Noon	Noon-1pm	1-2pm	2-3pm	3-4pm	4-5pm
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									

OR- I am not a student:

My Work Hours are:_____ Department Reception Phone Number:_____

Additional contact information:_____