THE PILLARS CHILD CARE
CHILD'S FILE CHECKLIST

THE PILLARS
CHILD CARE

___ Information Card

___ Emergency Medical Treatment Consent

___ Sunscreen/Diapering/Medication Form

___ Emergency Card

___ Parent Fee Contract

___ The Child's Information–"Get To Know Me"

___ Infant and Toddler Individual Needs Form, 6 weeks to 33 months

___ Infant Feeding Information Form

___ Child's Individual Needs Form, 33 months to 5 years

___ Authorization for Photography, Filming or Interviewing Form

___ Photo Release Permission Form

___ Parent Handbook Acceptance Form

___ Medication Administration Permission Prescription and Non-Prescription Form

___ Health Care Summary Form

___ Immunization Form

___ ACH Authorization Form

THE PILLARS CHILD CARE
INFORMATION CARD

THE PILLARS
CHILD CARE

Enrollment Date _____

Parent _____ Primary Phone _____

Address _____ Secondary Phone _____

City _____ Zip _____ State _____

Employer _____ Email _____

Parent Fairview/Ebenezer Person # _____

Parent _____ Primary Phone _____

Address _____ Secondary Phone _____

City _____ Zip _____ State _____

Employer _____ Email _____

Parent Fairview/Ebenezer Person # _____

CHILD

Name _____ _____ _____ Age _____
First MI Last

Address _____ Apt. # _____

City _____ Zip _____ State _____

Birth Date _____ Phone _____ Male ___ Female ___

EMERGENCY CONTACT

Those listed below are allowed to pick up my child(ren) if instructed by either parent or guardian. In case of an emergency please contact one of the following people if parents/guardian cannot be reached. Emergency contacts are also authorized to pick up my children. Complete information must be supplied. Name, address and telephone number.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Parent or Guardian Signature _____ Date _____

THE PILLARS CHILD CARE
EMERGENCY MEDICAL TREATMENT CONSENT

THE PILLARS
CHILD CARE

Child's Name _____ Birth Date _____

Child's Doctor _____ Clinic Name and Address _____ Phone _____

Child's Dentist _____ Clinic Name and Address _____ Phone _____

Preferred Hospital _____

Medications _____

Allergies _____

Other Significant Medical Information _____

Insured _____

Company and Policy # _____

Parent		Parent	
_____		_____	
Home/Cell	Work Phone	Home/Cell	Work Phone

AUTHORIZATION

I give permission to The Pillars Child Care to make decisions for whatever emergency (e.g. first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the center.

In case of a medical/dental emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource (police, rescue squad), deems it necessary.

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

Parent or Guardian Signature _____ Date _____

THE PILLARS CHILD CARE
SUNSCREEN/DIAPERING/MEDICATION FORM

THE PILLARS
CHILD CARE

SUNSCREEN

The Pillars sunscreen policy is as follows. The Pillars Child Care will proved a sunscreen lotion that is water resistant, hypoallergenic, papa-free, SPF between 30-70 UVA-UVB protection as needed for exposure to the sun. The teachers will apply in the morning and re-apply it in the afternoon. A $5.00 per summer fee will cover the cost of the sunscreen. A new form is sent home each spring to give permission for the use of sunscreen.

DIAPERING PRODUCTS

The Pillars diapering product policy is as follows. If your child needs diapering ointment, you provide the ointment and fill in a non-prescription medication form in their classroom and then we will administer the ointment during diaper changes per parent instructions. Any ointments/creams must be in the original container.

MEDICATIONS

The Pillars medication policy is as follows:

Over-the-counter: If your child's age is listed on medication, we will give the medication as directed on the box, with your completed written Medication permission form. We must have a written doctor's authorization form for any child under the age of 2, in order for staff to administer the medication. All medication must be in original container.

Prescription medications: Prescription medications must be in original container and a legible prescription label attached with the expiration date. A Medication Permission form must be completed by the parent in order for staff to administer medication.

All medications will only be given for the length of time that is listed on the Medication Permission form filled out by the parents. Parents must take the medication home when the child no longer needs it.

Parent or Guardian Signature _____ Date _____

THE PILLARS CHILD CARE
EMERGENCY CARD

THE PILLARS
CHILD CARE

Child's Name _____ Birth Date _____

Street Address _____

City, State, Zip _____

Parent or Guardian _____ Work Phone _____ Cell Phone _____

Parent or Guardian _____ Work Phone _____ Cell Phone _____

The following information is required by the Department of Human Services

EMERGENCY CONTACT/AUTHORIZED PICK UP

(in the event parents/guardians above cannot be reached, two other contacts must be provided below)

Name _____

Relationship _____ Phone _____

Address _____ City, State, Zip _____

Name _____

Relationship _____ Phone _____

Address _____ City, State, Zip _____

Physician _____ Phone _____

Address _____ City, State, Zip _____

Preferred Hospital _____

Allergies _____

Dentist _____ Phone _____

Address _____ City, State, Zip _____

Medications _____

Other Significant Medical Information _____

I give permission to _____ to make whatever emergency, (e.g., first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the center.

In case of a medical/dental emergency, I understand that my child will be transported to appropriate medical facility by the local emergency unit for treatment if the local emergency resource (Police, Rescue Squad) deems it necessary. The child will be transported at the expense of: _____.

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

By signing this form, I authorize _____ to release any information pertaining to my child to persons listed as an emergency contact or authorized pickup.

Parent or Guardian Signature _____ Date _____

THE PILLARS CHILD CARE
PARENT FEE CONTRACT

THE PILLARS
CHILD CARE

Child's Name _____ (First) _____ (MI) _____ (Last)

I _____ (Parent 1) and/or _____ (Parent 2)

agree to pay The Pillars Child Care the following amounts. I/We will pay $_____ per week to The Pillars Child Care for childcare services. Payments are due Thursday for the upcoming week. Payment options will include payroll deduction for Fairview/Ebenezer families only and ACH withdrawal for all families. If you choose to pay monthly, payments are due the 1st of each month. Your monthly payment is the number of weeks in that month times your weekly tuition amount.

II/We understand that if the payment is received past the agreed upon payment date, we will be charged as follows: A late fee of **$5.00** per day will be charged for payments not made. In addition, I/We understand and agree that an additional fee of **$2.00** per minute will be charged if your child(ren) are not picked up within the 5:30 p.m. closing time. I/we are responsible to pay any legal fees that might be incurred while collecting a debt.

Insufficient Funds: If a check should be received back, a $35.00 fee will need to be paid in cash for each NSF check. This fee must be paid in cash.

# DAYS PER WEEK	DAYS AND HOURS OF CHILD'S ATTENDANCE
Monday Hours:	
Tuesday Hours:	
Wednesday Hours:	
Thursday Hours:	
Friday Hours:	

Termination of services: I/we agree to give a 30 day, written notice if we need to discontinue childcare services. I/we are responsible for payment even if the child is not in attendance.

I/we understand and agree to all of the above terms. Both parents must sign (if applicable).

Parent Signature _____ Date _____

Parent Signature _____ Date _____

THE PILLARS CHILD CARE
THE CHILD'S INFORMATION

THE PILLARS
CHILD CARE

GET TO KNOW ME!

Child's Name _____ _____ _____
First MI Last

Nickname _____ Birth Date _____

My child lives in the home with _____

_____

Daily Routine _____

_____

_____

Sleeping Habits _____

_____

Child's Fears _____

_____

Known Food Allergies _____

Eating Habits _____

List any behavioral problems we should know about _____

_____

Is your child Toilet Trained? Yes _____ No _____

Is there any other information that would help your child have a pleasant experience at The Pillars Child Care?

_____

_____

_____

THE PILLARS CHILD CARE

INFANT AND TODDLER INDIVIDUAL NEEDS FORM (6 WEEKS TO 33 MONTHS)

THE PILLARS
CHILD CARE

Child's Name _____ _____ _____
First MI Last

Nickname _____ Birth Date _____

Eating Habits _____

Food Allergies _____

Food Restrictions _____

Medical Needs _____

Sleeping Habits _____

Toileting _____

Child's Communication Habits _____

Child's Comforting Needs and Methods _____

Child's Likes _____

Child's Dislikes _____

Infant Parents: The infant teachers will give you a menu when you want your child to start table foods. You can let them know each week, what foods to add to your child's diet.

Parent or Guardian Signature _____ Date _____

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THE PILLARS CHILD CARE
INFANT FEEDING INFORMATION FORM

THE PILLARS
CHILD CARE

Child's Name _____ Birth Date _____ Current Date _____

__ My child is breast fed. Parent must provide prepared, labeled bottles and bring in each day in a secured, enclosed, labeled container.

__ My child is bottle fed.

Type of bottle _____ Type of nipple _____ Number of oz. _____ every _____ hours.

(Parents will provide 3 labeled bottles/nipples to leave at The Pillars for their child.)

__ My child drinks from a _____ sippy cup or _____ regular cup

__ My child uses a spoon.

__ My child uses formula _____ brand. We provide Enfamil and Similac.

Please mark all foods your child can eat. Mark the date by each food as you update this form.

Infant Cereal	Strained Fruit	Strained Vegetables	Strained Meat
___ Rice	___ Bananas	___ Squash	___ Chicken
___ Oatmeal	___ Pears	___ Green Beans	___ Beef
	___ Apricots	___ Carrots	___ Turkey
	___ Peaches	___ Peas	
	___ Applesauce	___ Sweet Potatoes	

__ My child eats table food. See the current menu to mark approved table foods.

Parent or Guardian Signature _____ Date _____

Monthly Review _____ Parental Initials _____ Date _____

THE PILLARS CHILD CARE

CHILD'S INDIVIDUAL NEEDS FORM (33 MONTHS TO 5 YEARS)

THE PILLARS
CHILD CARE

Child's Name _____ _____ _____
First MI Last

Nickname _____ Birth Date _____

Eating Habits _____

Food Allergies _____

Food Restrictions _____

Medical Needs _____

Sleeping Habits _____

Toileting _____

Child's Communication Habits _____

Child's Comforting Needs and Methods _____

Child's Likes _____

Child's Dislikes _____

Special Educational/Dietary needs requiring an ICCP or an IEP _____

Parent or Guardian Signature _____ Date _____

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THE PILLARS CHILD CARE

AUTHORIZATION FOR PHOTOGRAPHY, FILMING OR INTERVIEWING FORM

THE PILLARS
CHILD CARE

Child's Name _____ Birth Date _____
Please Print

Street Address _____

City, State, Zip _____

Home/Cell _____ Work Phone _____

FAIRVIEW, EBENEZER FACILITY

I hereby expressly grant to Fairview/Ebenezer/ The Pillars the right to make, use and/or publish information, photographs, or any other reproductions of my physical likeness for various Fairview/ Ebenezer/The Pillars communications efforts, such as pamphlets, booklets, videotapes, audiotapes, slide shows or each organization's Internet web site.

In addition, I expressly grant this right to be used for educational, marketing and/or promotional information by Fairview or Ebenezer for its professional and staff communications, public relations, marketing, and public health information programs.

If the use of the photographs or my physical likeness will reveal or imply information about my medical condition(s)_____

_____
List condition(s) here

the authorization for the use of these photographs will expire after _____ years (1–99).

Parent Initials _____

MEDIA

I hereby expressly grant consent to be photographed, filmed and/or interviewed by a representative of_____

_____
(Media name of newspaper, magazine, TV or radio station)

and to have information about the following medical care _____
(list specific conditions, treatments and dates of service)

released to same by my physician and/or staff member at _____
(Facility name)

member at _____
(Describe use to be made of patient information)

This authorization will expire after_____ (fill in period of time or an event).

I understand that Fairview shall not be responsible for the media's use of any films, photographs or interviews, or of any patient information that I have consented to release.

Fairview may use resulting media coverage in its internal or external promotional activities.

Parent Initials _____

- I understand I may revoke this authorization by written request to Fairview Media Relations at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once information is released pursuant to this authorization, Fairview can not prevent the re-disclosure of the information to another third party.
- Fairview will not condition treatment on my signing this authorization.
- It is understood that the foregoing authorization is subject to the following LIMITATIONS:

_____ _____
(Indicate any limitations or NONE) *(Parent Initials)*

Signature of Parent/Authorized Person _____ Date _____
(If authorized person is signing, please also print name)

Authorized Person's Authority to Sign_____ Date _____
(parent, guardian, power of attorney, etc.)

THE PILLARS CHILD CARE
PHOTO RELEASE PERMISSION FORM

THE PILLARS
CHILD CARE

Photographs are taken on different occasions such as birthdays, holidays and special occasions and most of the events on our campus. Because we participate in many Intergenerational programs, we take many photos and and/or video of the events that take place at The Pillars Child Care Intergenerational Campus. This form provides permission to have your child photographed and/or video recorded at any and all events on our campus. This form provides permission for your child's photo or video to be used in various media forms. This form also provides permission to have your child's photo used within our campus for display purposes.

Child's Name _____

Please mark the appropriate area:

I ____ give/ ____ do not give Ebenezer/The Pillars permission to take or have taken photo's of my child if the occasion should arise.

I ____ give/ ____ do not give Ebenezer/The Pillars permission to have my child video-recorded should the occasion arise.

I understand these photos will not be sold or distributed without my knowledge or permission.

Parent or Guardian Signature _____ Date _____

EMAIL PERMISSION

I ____ give Ebenezer permission to use the following email address(es) _____ _____ to communicate various information pertaining to my child, Ebenezer and billing.

Parent or Guardian Signature _____ Date _____

WALKING FIELD TRIP PERMISSION FORM

Part of our everyday activities may include walks throughout the Ebenezer community and through different parts of the facility and up to a ½ mile walking distance around our campus. This may require crossing public streets and walking on city sidewalks. Since this is often a daily event, we would like an open-ended permission slip for participation in these activities.

My child,_____ DOB,_____,has my permission to participate in activities on and around campus, while being accompanied by a qualified CPR and First Aid certified child care staff.

Parent or Guardian Signature _____ Date _____

THE PILLARS
CHILD CARE PROGRAM

PARENT HANDBOOK ACCEPTANCE FORM

Child's Name: _____ Enrollment Date: _____

Child's Name: _____ Enrollment Date: _____

Parent(s) Name: _____

I have received and read the Parent Handbook for The Pillars Child Care Program. I agree to all of the policies and procedures therein. I understand that if I have any questions regarding The Pillars Child Care Policies and Procedures that I can ask the Director of Child Care.

Parents Signature: _____ Date: _____

Parents Signature: _____ Date: _____

THE PILLARS
CHILD CARE

THE PILLARS CHILD CARE

MEDICATION ADMINISTRATION PERMISSION PRESCRIPTION AND NON-PRESCRIPTION FORM

THE PILLARS
CHILD CARE

All medication given to children under 2 years of age requires a physician permission form.

Child's Name _____ Child's Age _____

MEDICAL INFORMATION

Circle one: Prescription or Non-Prescription

Name of Medication to be given _____ Prescription # _____

Medical reason for RX _____

Possible side effects _____

Special instruction _____

Precautions _____

Pharmacy name _____ Pharmacy Phone # _____

Date medication started _____ (MM/DD/YY) Last date medication to be given _____ (MM/DD/YY)

Prescription dosage _____ Time of Day _____

Discarded or returned to parent on _____

MEDICATION SCHEDULE *(to be filled out by person administering medication–including their full name)*

Prescription Name	Amount Given	Time Given	Administered By	Date Given

(Attach another sheet to keep logging if need more room. Turn sheet into administrator once medication is complete.)

I hereby give permission to The Pillars Child Care to administer the above medication as instructed by me and if a prescription, as prescribed by my physician.

Parent Signature _____ Date _____

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THE PILLARS CHILD CARE

HEALTH CARE SUMMARY
(MUST BE COMPLETED BY HEALTH CARE SOURCE)

THE PILLARS
CHILD CARE

Enrollment Date _____

Name of Child _____ Birth Date _____

Address _____ Telephone _____

Parent(s) or Guardian _____

Date of physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

In any condition present that might result in an emergency? _____

What is the status of the child's... Vision _____

Hearing _____

Speech _____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

Signature of Health Source _____ Date _____

Address _____ Phone _____