APPLICATION FOR ENROLLMENT

Bethlehem
CHILD CARE CENTER
3141 43rd Ave S
Minneapolis, MN 55406
612-721-2290, phone
612-721-6573, fax
bethlehemchildcarecarecenter@gmail.com

Today's Date: _____

Child's Name: _____ **Male / Female**

What name do you want your child called at BCCC? _____

Child's Date of Birth: _____

Program: Beginners Pre-Kindergarten School Age

Child's Address: _____

_____

Parent /Guardian(s):

1. Name: _____ Occupation: _____

Parent address, if different from child's: _____

Home#: _____ Work# _____ Cell# _____

E-mail: _____ cell phone carrier (for texts): _____

2. Name: _____ Occupation: _____

Parent address, if different from child's: _____

Home#: _____ Work# _____ Cell# _____

E-mail: _____ cell phone carrier (for texts): _____

Marital Status of Parents/Guardians: _____

Custody-Visiting Arrangements: _____

EMERGENCY INFORMATION (Required)

Child's Health Clinic/Doctor: _____

Address: _____ Phone: _____

Child's Dentist: _____

Address: _____ Phone: _____

We are required to have a minimum of 2 emergency contacts: name, address & phone

Persons to be called in case of emergency/authorized to pick up child (other than parent):

1. Name: _____ Relationship to child: _____

   Address: _____ Phone: _____

2. Name: _____ Relationship to child: _____

   Address: _____ Phone: _____

Anyone who MAY NOT pick up your child: (example: a parent without custodial rights):

_____

***Unless otherwise indicated we will assume that emergency contacts are also authorized to pick up your child.**

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CHILD CARE CENTER

School Age Contract Sheet 2019/20

(submit this form if you have not submitted it online)

Child's Full name _____ Grade entering in Fall: _____

What school does your child attend?

Seward Emerson Hiawatha Howe Dowling

Parent/Guardian's Name _____ phone number: _____

Parent/Guardian's email: _____

BCCC bills by the contracted hour. Take the weekly total number of hours and, for any number which is not a whole number by more than a quarter of an hour, round up. (Example: total weekly hours are 8.5, round to 9 hours; if total weekly hours are 6.25 round to 6 hours). The hourly rate for 2019-20 school year is $7.65.

Minimum requirements: enrolled at least 2 days and 4 total hours per week.

Fees: $40 reservation fee will be applied to your child's October tuition if there are no changes to this requested schedule between June 7 and September 27, 2019.

If your child is moving from our preschool program and entering our school age program you need to submit an updated physical and immunization record. These will be emailed to you shortly after you submit this registration.

For new children, there is a one-time, non-refundable registration fee of $60 along with the $40 reservation fee. You will also need to fill out a complete registration packet and submit it to hold your child's space. Packet's will be emailed to you about a week after you submit this form.

Will your child attend in the morning? If so, which days and what time will you drop off?

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Will your child attend after school? If so, which days and what time will you pick up?

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Parent/Guardian Signature _____ Date: _____

B.C.C.C. NEW CHILD INFORMATION

Bethlehem CHILD CARE CENTER

How did you come to know about BCCC? _____

_____

Please describe previous experiences your child had with child care/preschool? _____

_____

What do you hope your child will gain from enrolling at BCCC? _____

_____

_____

What would you like your child's teachers to know about his/her style? _____

_____

_____

Does your child nap? _____ When? _____

What time does your child go to bed at night? _____ Wake up? _____

Does your child have any special fears? _____

Does your child have any problems with vision or hearing? If so, please explain _____

_____

Does your child receive any special services? If so, please explain. Do you have any concerns about any aspect of your child's development? _____

_____

Has your child had any serious accidents or operations? If so, please describe _____

_____

Does your child play well alone? _____ In groups? _____

Please circle words below that describe your child:

Happy	Aggressive	Dependent	Stubborn	Clumsy	Alert
Friendly	Good-natured	Impulsive	Fearful	Quiet	Active
Moody	Even-tempered	Attentive	Sympathetic	Sleepy	Slow to warm up

Other: _____

What are the names and ages of other siblings? Any other information that would help us get to know your child's family better (step-parents, grandparents, adoption, other care givers)? _____

_____

To help us celebrate and reinforce your child's cultural background please tell us about holidays and special days that are celebrated in your home. _____

_____

Health Information

Bethlehem CHILD CARE CENTER

Child's Name: _____

Allergies	Reaction(s)
Medication	
Food	
Environmental	
Other	

If your child has any allergies you will be required to fill out an Individual Allergy Action Plan along with your doctor/clinic. This form will be sent later. BCCC must be given medication prescribed by your doctor for emergency treatment for all allergies.

Other Significant Medical/Educational Information: Asthma, IEP, Speech, Developmental Delay…. You may be required to have your doctor fill out an Individualized Child Care Plan (ICCP) – this form will be sent later. Note: If your child has an IEP we are required to have a copy.

_____

_____

_____

In order for your child to attend each day, the medication the treatment plan lists must be at BCCC.

Current Medications: _____

Note: Parent/Guardian will be required to fill out Medication Permission Form anytime staff are asked to dispense medication.

Dietary Needs:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

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CHILD CARE CENTER

Child's Name:	
Emergency Care I give permission to BCCC staff to make whatever emergency (ex. First aid, disaster, evacuation) measures are judged necessary for the care & protection of my child while under the supervision of BCCC. In case of 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 deems it necessary. The child will be transported at the expense of the family. It is understood that in some medical situations, staff may need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the child's behalf is contacted.	Parent/Guardian Signature: _____ Date: _____
Nurse/Health Consultant I understand that BCCC nurse/health consultant has access to my child's file during center visits.	Parent/Guardian Signature: _____ Date: _____
Photographs/Video I give permission for my child's image to be used in photographs within the center (bulletin boards, crafts, booklets...).	Parent/Guardian Signature: _____ Date: _____
Photographs/Video I give permission for my child's image to be shared on the classroom electronic updates and on the digital slideshow in the center's hallway.	Parent/Guardian Signature: _____ Date: _____
Photographs/Video I give permission for my child's image to be used on BCCC website and publications.	Parent/Guardian Signature: _____ Date: _____
Student Directory Each year BCCC puts together a student directory. The purpose is to help the children and families connect with other classmates if they choose. It will include child's name and photo; parent's name, address, phone number, and email. Please choose one of the three options listed: ☐ I give permission to have my child included in the directory. ☐ I only want my child's name included in the directory. Do not include personal information or a photo. ☐ I do NOT want my child included in the directory.	Parent/Guardian Signature: _____ Date: _____
I give permission BCCC staff to: ☐ Apply sunscreen ☐ Take my child on local walks in the neighborhood and to Cooper Park (32nd St & 43rd Ave)	Parent/Guardian Signature: _____ Date: _____

Bethlehem
CHILD CARE CENTER

BCCC Allergy Policy - Acknowledgment

The Bethlehem Child Care Center [BCCC] has some unique characteristics. For example, every child in the preschool program and pre-kindergarten program may bring his or her own lunch. Further, the BCCC incorporates field trips in the curriculum as well as trips to neighboring parks in summer and winter. Further, the use of the entire BCCC facility (including an indoor play area) is also used by church members and invitees to the Church, including other children. Because of these unique characteristics, BCCC cannot ensure that a child with a severe food allergy will not be exposed to the food or substance to which that child is allergic or sensitive.

Parents or guardians of children with a severe food allergy or sensitivity must make childcare staff and the Director aware of their child's food allergies and/or intolerance. Further, every child who has been prescribed an epinephrine auto-injector must have the epi-pen(s), in its original container and current prescription information on the label, given to the staff and kept at the center. Expired medicine, including epi-pens, may not be administered. If a child who has been prescribed an epinephrine auto-injector plans to go on a field trip, the staff will always take the epi-pen(s) along, so it will be readily available in the event of an emergency away from the BCCC.

I, _____, have read the attached Bethlehem Child Care Center Allergy Policy. I am signing this acknowledgment because I understand that BCCC cannot ensure that my child, _____, who has a severe allergy to _____ will not be exposed to the above-stated in the childcare center, or at any time while my child is in the care and custody of BCCC.

_____ _____

Date Signature of Parent or Guardian

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

(or submit the Health Care Source's form that covers theses areas)

Name of Child: _____ **Birth Date:** _____

Address: _____ **Telephone:** _____

Parent(s) or Guardian: _____

Date of last 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? _____

Is 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: _____

Phone: _____ **Address:** _____

_____

Date: _____

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I understand that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me
on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)