



3141 43<sup>rd</sup> Ave S.  
Minneapolis, MN 55406  
612-721-2290, phone  
bethlehemchildcare@yahoo.com

Dear Preschool Families,

We are excited that you are interested in BCCC for your child's preschool and, possibly, child care. Below you will find information listing what forms you need to turn in to BCCC. Enrollment begins on Monday, February 3, 2020 for currently enrolled families, previously enrolled families and church members. On President's Day – February 17, 2020 - we will open enrollment for new families.

If you are registering a child that is **currently enrolled** you will only need to submit two forms, "Application for Enrollment" and "Preschool Contract" along with a \$100 reservation fee. Although, if your child has updated any immunizations throughout the past year you need to submit a new immunization form.

If your **child has not attended** BCCC previously, include the \$100 reservation fee plus a \$60 registration fee- this can be one check- along with completed enrollment packet. Packets must be complete, including the Health Care Summary and Immunizations. Incomplete packets will be returned, and a spot for your child will not be held.

Explanation of Fees:

Registration Fee is a \$60 non-refundable fee for new children.

Reservation Fee is a \$100 fee per child, with a maximum of \$200 per family. This reservation fee will be credited to October's tuition if there is no termination or change of any requested care, per confirmed contract, between June 1 and October 1. If termination or change occurs between June 1 and October 1 this reservation fee will be retained by BCCC.

Here is a complete list of forms to include when you submit your paperwork:

- Application for Enrollment
- Preschool Contract
- BCCC New Child Information
- Health Information, filled out by parents/guardians
- Authorization for emergency care, photos, directory, sunscreen, local walks
- BCCC Allergy Policy-Acknowledgement
- Health Care Summary filled out by your Health Care Source or the form the clinic uses. \*Even if your child will be going to the doctor soon, submit the latest summary and turn in the updated form once the child's visit is complete.
- Immunization Record, our form or a form generated by your clinic
- If your child has an IEP, allergies, or other special needs you will have additional forms to fill out- please let us know so we can send you the correct form.

We will enroll children based on these criteria:

1. The order in which we receive completed paperwork.
2. Beginners: children must be 3 by September 1. Pre-K: children must be 4 by September 1.
3. For applications in the Beginners room: children who turn 3 between September 1 and October 1 will be automatically added to the Wait List. They will be eligible to be assigned to Beginners if there are openings after June 1.
4. Children who turn 3 after October 1 will not be enrolled in the program.

Thank You,  
Jill Ravensborg, Director

# APPLICATION FOR ENROLLMENT



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Minneapolis, MN 55406  
612-721-2290, phone  
612-721-6573, fax  
bethlehemchildcarecenter@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.**

**Preschool Contract Sheet 2020-21**



Please complete, sign and return this form with the child’s application paperwork, registration fee and reservation fee. Enrollment begins on Monday, February 3, 2020 for currently enrolled families, previously enrolled families and church members. On February 17, 2020, we open enrollment for new families.

A non-refundable registration fee of \$60.00 is due with completed application for all new children. A reservation fee of \$100 is also due with application for all children. The check amounts can be combined. This reservation fee of \$100 will be credited to your October tuition if there is no termination or change of any requested care, per this contract, between June 1, 2020 and October 1, 2020. If termination or change occurs between June 1 and October 1 this reservation fee will be retained by BCCC.

We will need care for \_\_\_\_\_ (print Child’s Full Name) in:

- Beginners mornings (9 a.m. -12 p.m.) (children who are 3, turning 4)
- Lunch Bunch (Beginners only, 12 p.m. – 1 p.m.)
- Circle your request(s):** Beginners Full Day program (between 7 a.m. and 6 p.m.), limit of 10 hrs/day
- Pre-K mornings (9-1 pm) (children will enter K the fall of 2019)
- Pre-K Full Day program (between 7 a.m. and 6 p.m.), limit of 10 hrs/day

Place an X in the appropriate day/space for which you want to enroll your child. Children must be enrolled for a minimum of 2 days, of any combination of full day or a.m. programs.

Monday		Tuesday		Wednesday		Thursday		Friday	
a.m. only	full day	a.m. only	full day	a.m. only	full day	a.m. only	full day	a.m. only	full day

**Tuition Rates 2020 - 2021:**

- Half Day Rates: Beginners (9 am – 12 pm)           \$25.40 per day
- Lunch Bunch (12 pm – 1 pm)         \$ 7.65 per day
- Pre-Kindergarten (9 am – 1 pm)         \$30.00 per day
- Full Day Rates: 1 Full day                                 \$55.50 per day
- 2 Full days   \$111.00 per week
- 3 Full days   \$166.50 per week
- 4 Full days   \$212.00 per week
- 5 Full days   \$252.50 per week

Total mornings/days per week: \_\_\_\_\_ Weekly rate to be charged: \_\_\_\_\_

BCCC has a scholarship program to provide financial assistance to those who might not otherwise be able to afford the full cost of quality childcare. The assistance is granted in the form of partial tuition scholarships, contingent upon the availability of funds. Funds are designated in May - please notify Jill if you want an application.

Note: Our billing cycle is billed in 4-week cycles and tuition and fees are due before care is provided. We require a 2-week written notice if you decide to terminate service or change a child’s schedule. You will be billed for those two weeks. Additional days may be added, dependent upon availability.

I agree to pay Bethlehem Child Care Center the agreed fees for the services rendered on or before the due date as set forth on this form, by the parent handbook and/or monthly tuition statements.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

B.C.C.C. NEW CHILD INFORMATION



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

**Child's Name:** \_\_\_\_\_

<u>Allergies</u>	<u>Reaction(s)</u>
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.

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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:

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Child's Name:</b>	
<b>Emergency Care</b> 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: _____
<b>Nurse/Health Consultant</b> I understand that BCCC nurse/health consultant has access to my child's file during center visits.	Parent/Guardian Signature: _____ Date: _____
<b>Photographs/Video</b> I give permission for my child's image to be used in photographs within the center (bulletin boards, crafts, booklets...).	Parent/Guardian Signature: _____  Date: _____
<b>Photographs/Video</b> 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: _____
<b>Photographs/Video</b> I give permission for my child's image to be used on BCCC website and publications.	Parent/Guardian Signature: _____ Date: _____
<b>Student Directory</b> 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: _____
<b>I give permission BCCC staff to:</b>  Apply sunscreen  Take my child on local walks in the neighborhood and to Cooper Park (32 <sup>nd</sup> St & 43 <sup>rd</sup> Ave)	Parent/Guardian Signature: _____  Date: _____



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.

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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.

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Date

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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 these 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

<u>Important Health Problems</u>	<u>Followed by you</u>	<u>Followed by Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the child care program \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Health Source:** \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**Date:** \_\_\_\_\_



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.

# Immunization Form

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

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

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

## Vaccine

Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Haemophilus influenzae type b (Hib)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PCV)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Measles, Mumps, Rubella (MMR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chickenpox (varicella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal (MCV4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

- 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.
- 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.

**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		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

**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 am aware 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)

Notary Stamp

Notary Signature: \_\_\_\_\_

STATE OF MINNESOTA, COUNTY OF \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of health care practitioner\*)

**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)