



bethlehemchildcarecenter@gmail.com

Dear School Age Families

We are excited that you are interested in BCCC for your child's before and after school care.

If you are registering a child that is **currently enrolled** you will only need to submit 3 forms: "Application for Enrollment", "School Age Contract", & "Authorization Form" along with a \$40 reservation fee (if you want this added to your account, we can do that and you do not need to include a check or cash). If your child has updated any immunizations throughout the past year, please submit a new immunization form or the record from your clinic.

If your **child has not attended** BCCC previously, include the \$40 reservation fee plus a \$60 registration fee- this can be one check- along with a completed enrollment packet. Packets must be complete, including the Health Care Summary and Immunizations. Incomplete packets will not hold a spot for your child.

Explanation of Fees:

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

Reservation Fee is a \$40 fee per child. 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.

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

- Application for Enrollment
- School Age Contract
- BCCC New Child Information
- Health Information- filled out by parents/guardians
- Authorization Form
- BCCC Allergy Policy-Acknowledgement
- Health Care Summary filled out by your Health Care Source or the form the clinic uses. Some of the MyCharts type of forms do not include the information needed, compare to our form before submitting. *Submit the latest form, even if your child will be going to the doctor soon, then 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, please notify the office. You and your child's doctor will have additional forms to submit.

We will enroll children based on these criteria (in the order in which we receive registration requests):

- currently enrolled families (priority extends until March 8),
- previously enrolled families,
- new families

APPLICATION FOR ENROLLMENT



3141 43rd Ave S

Minneapolis, MN 55406

612-721-2290, phone

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: Preschool 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.**



School Age Contract Sheet 2024/2025

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

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

What school will your child attend? The time is my best guess for bussing.

Dowling (9:15, 4:15) Hiawatha (9:15, 4:15) Howe (9:15, 4:15) Seward (9:15, 4:15)

Parent/Guardian's Name _____ phone number: _____

Parent/Guardian's email: _____

BCCC bills by the contracted by the shift. The rate for 2024-25: Morning (7:30 – 9:15 is \$13/day) Afternoon (4:10 – 5:30 is \$10/day) Release Days will bill at \$55/day.

Minimum requirements: enrolled at least 3 days a week.

Fees: \$40 reservation fee which will be applied to your child's October tuition if there are no changes to this requested schedule between June 1 and October 1.

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. Packets can be found on our website, under the "Tuitions & Fees" tab.

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. Please find the forms included in our enrollment packet on our website, under the "Tuition & Fees" tab.

Will your child attend in the morning? \$13/day

Monday	Yes	No
Tuesday	Yes	No
Wednesday	Yes	No
Thursday	Yes	No
Friday	Yes	No

Will your child attend after school? \$10/day

Monday	Yes	No
Tuesday	Yes	No
Wednesday	Yes	No
Thursday	Yes	No
Friday	Yes	No

Total Weekly Tuition: _____

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. Please request the additional forms from the office immediately. BCCC must be given medication prescribed by your doctor for emergency treatment for all allergies noted.

Other Significant Medical/Educational Information: Asthma, IEP, Speech, Developmental Delay.... You will likely be required to have your doctor fill out an Individualized Child Care Plan (ICCP) – please request the additional form from the office immediately. Note: If your child has an IEP we are required to have a copy.

In order for your child to attend, the medication and treatment plan must be at BCCC prior to their first scheduled date.

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: _____

Authorization Form

Please read the following descriptions and check the appropriate boxes for which you grant permission.

- 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.
- Nurse/Health Consultant:** I understand that BCCC nurse/health consultant has access to my child's file during center visits.
- Diffuse Essential Oils:** I give permission for my child to be in a room that uses an essential oil diffuser.
- Photographs/Video:**
 - I give permission for my child's image to be used in photographs within the center (bulletin boards, crafts, booklets...).
 - 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.
 - I give permission for my child's image (no name or personal information) to be used on BCCC website and publications.
- Student Directory:** Each year BCCC puts together a student directory. The purpose is to help the children and families connect with other classmates. 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.
- I give permission BCCC staff to:**
 - Apply sunscreen
 - Apply lotion, as needed
 - Hand sanitizer, when water is not readily available (ex. at a park)
 - Take my child on local walks in the neighborhood and to Cooper Park (32nd St & 43rd 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 brings 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 For Child Care Attendance

Form H-300

To be completed by health care provider

Program Name: Bethlehem Child Care Center

Child's Name:

Child's Date of Birth:

Parent/Guardian:

Date of last physical exam:

Is the child up to date on immunizations? YES NO

If no, plans for bringing the child up to date:

Allergies:

Does the child have any important health concerns that you are following them for?

Does the child:

- **have any special needs that require accommodation by the provider?**
- **have any conditions that may result in an emergency?**
- **Is a modified diet necessary?**
- **have any activity restrictions?**

What is the status of the child's Vision:

Hearing:

Speech:

Is there any other information that would be helpful in a group care setting?

**Does the child have any important health concerns that are followed by another source of health care?
(if so, please give name of provider and condition requiring attention)**

Primary health care provider name:

Clinic name/phone number:

Provider Signature/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"/>
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Haemophilus influenzae</i> type b (Hib)	<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"/>
Polio	<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"/>
Chickenpox (varicella)	<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"/>
Tetanus, Diphtheria, Pertussis (Tdap)	<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"/>

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.



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		
<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)

by _____ (name of parent or guardian)



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.

- 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:

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.
Minnesota Department of Health - Immunization Program (2019)